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FIVE CASES PRESENTING POINTS OF SPECIAL CLINICAL INTEREST*

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I am decidedly of the opinion that the usual method of reporting instances of rare conditions is a prejudicial one, in no way tending to render the rank and file of physicians any better diagnosticians, at present the crying need of the profession. Too often the reverse obtains, because the reporters describe how rarely, in their vast experience, still more in that of the profession at large, are such cases met with, ergo, the audience need not bother about such occurrences as they will probably never run across any such. On the other hand, certain common ailments are believed to be so well understood that, when these occur at an unusual age or under circumstances which appear to the superficial observer to preclude the possibility of the presence of such diseases, serious errors in diagnosis and treatment are made.

The first case I shall mention is one of fistula-in-ano in an infant, aged between seven and eight months. One portion of the profession still believes in the tuberculous origin of this disease, while the majority of the remainder have a hazy

notion that in some way, trauma of the mucous membrane, followed by ulceration with resultant peri-rectal abscess, is the usual cause of this condition. These notions comprise but a portion and probably the smaller portion of the truth, in many cases the process starting as a lymphatic infection, or possibly an infective thrombo-phlebitis of the ischio-rectal fossa, a denudation of the rectal coats by the pus, and a progress of the infection and the pus in the direction of least resistance, i. e., inwards, between the internal and external sphincters of the anus, guided thither by the fascia of the levator ani muscle. When a complete anal fistula results, the skin opening may possibly form first, but there is often evidence, when incising an ischio-rectal abscess, that a minute opening into the bowel (or at least a potential one) has preceded the advent of the pus beneath the thinned integument.

The impression that infants do not have tuberculosis of the anal region and being fed on liquids cannot have fish-bones or fragments of other bones, etc., in the rectum to produce trauma and ulceration of the mucous membrane, does not preclude lymphatic infection through

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temporary fissures of the anal mucocutaneous covering produced by costive movements, etc. (in my experience incontestably the most common cause of the ischio rectal abscesses causative of anal fistulae), nor can these cases be treated otherwise than in the adult, i. e., detection of the opening into the bowel and slitting up the whole tract.

In the briefest form the history of the case mentioned is as follows: The patient is now thirteen months of age. About five months ago the patient had a severe attack of gastro-intestinal trouble with diarrhea which lasted four weeks. A swelling then appeared to the left of the rectum which so compressed the anus that the bowels could not be evacuated for 24 hours. At the end of this time, during an effort to empty the bowels, the swelling ruptured, discharging much pus and blood. The skin opening closed on several occasions, but opened again, giving vent to pus. Some form of operation was done in February, since which time the discharge has been much less. Examination under an anesthetic enabled the easy passage of the probe along the sinus into the rectum between the two sphincters. This tract was freely laid open and packing was introduced, healing promptly taking place.

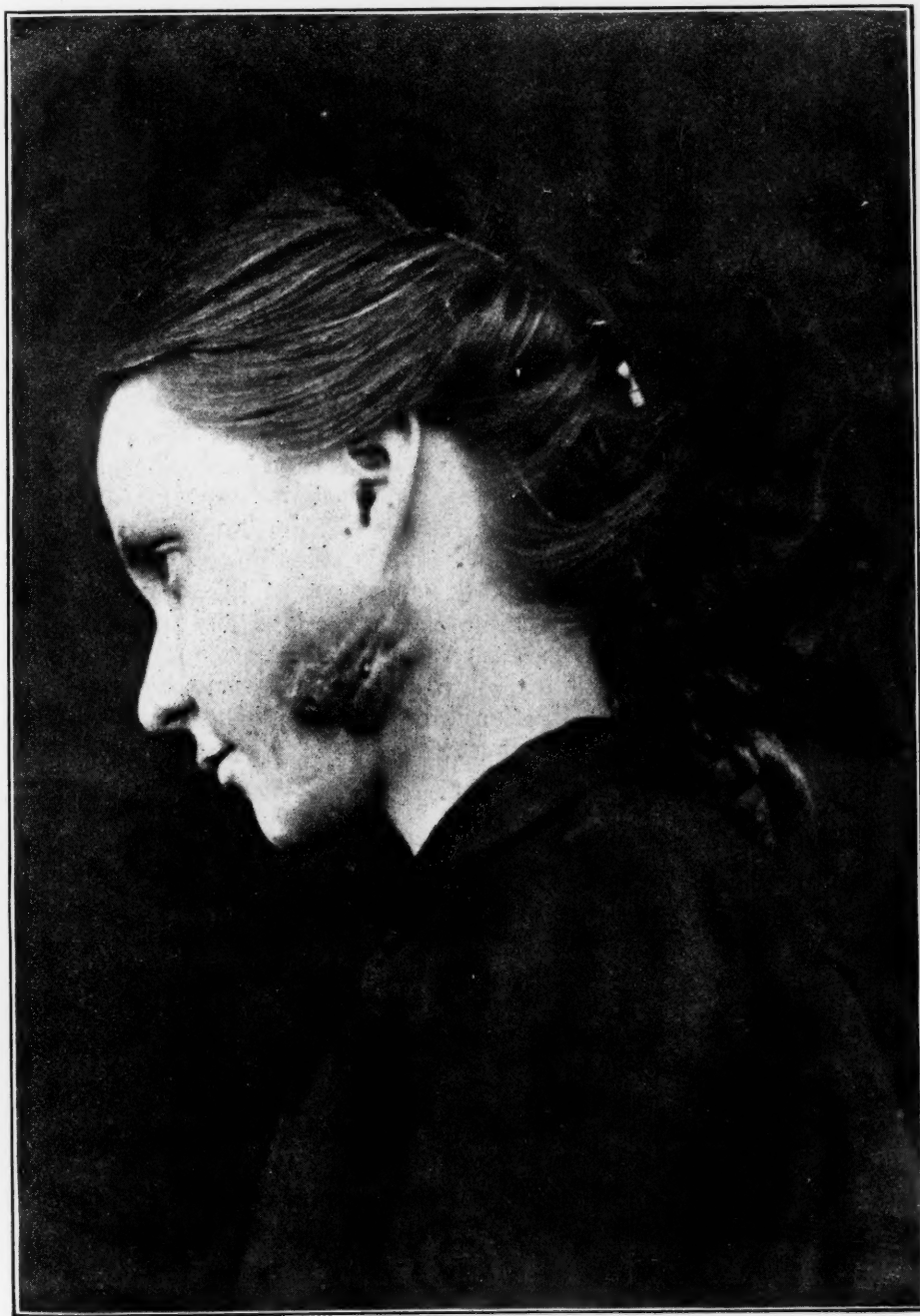
The general belief that the symptoms, course, and diagnosis of deep-seated abscess, osteomyelitis and sarcoma are thoroughly understood, and that the differential diagnosis between these can be readily made, together with a misconception as to the prevalence, the symptoms, the course, the diagnosis and pathognomic symptoms of actinomycosis, frequently leads to both errors of diagnosis and failure in treatment. This disease is far more prevalent than is usually believed. The reason for its infrequent detection is due to the fact that the description in the books is such as to lead to the following misconceptions, viz.,

that it occurs chiefly, if not solely, among those engaged in agricultural pursuits and that it is quite usual to find that an animal suffering from "lumpy jaw" is, or has been, on the farm. Another error is that the discharge will invariably contain gritty, calcareous particles of sulphur yellow bodies, while as a matter of fact the so-called fishroe bodies (at least in this country) are far commoner than the other two forms of granules, and these are not easy of detection, while they are also absent for variable periods from the discharge. The description in the books still further leads astray by inducing the readers to believe that the ray-form of the fungus can be readily and easily detected in the discharges, whereas it may require prolonged and careful search, even after proper staining, to detect the filamentous form of the organism which branches at acute angles. Finally, recent investigations seem to go to prove that the idea commonly prevalent that the organism is introduced into the tissues from without is probably incorrect. It is taught that the organisms enter through a carious tooth, or through damages of the buccal or intestinal mucous membrane induced by foreign bodies from without, such as beards of grain or pieces of straw contaminated with the organism. This is probably a misrepresentation of the facts. The organism in the filamentous form has been probably shown to have its normal habitat in the buccal cavity, and there is ground for belief that the rôle played by pieces of straw and other vegetable materials is that simply of vulnerating objects providing an infection atrium in tissues of lowered resistance. The histories of the succeeding cases speak for themselves.

A school girl aged 17 entered the hospital January 12, 1907, stating that trouble had been noticed with an aching tooth in the left side of the lower jaw in September, 1906. In Janu-

ary, 1907, the tooth was extracted, was found to be healthy, and no disease was found in the alveolus. A

was extracted and has steadily and rapidly increased since that time. Occasional dull pain at night was complained of.



large swelling of the cheek and temporal region commenced shortly after the tooth

The left cheek seemed pushed outwards by a diffuse enlargement extending from

below the lower jaw upwards to the zygoma, and posteriorly bulging about one centimeter behind the ramus. By palpation no sharply defined tumor could be made out, the whole mass moving with the inferior maxilla when the patient opened or closed the mouth. The trouble evidently involved the pterygoid and masseter muscles—possibly the temporal; (this suspicion proved later to be correct). Opposite the last upper molar tooth there was a small opening in the mucous membrane, giving vent to pus. No fluctuation could be detected anywhere. By enlargement of this opening about a dram of pus was evacuated, but in a few days softening with fluctuation developed near the angle of the jaw; this ruptured, giving vent to a moderate amount of pus. Two months later a large fluctuating tumor appeared above the zygoma in the temporal fossa. Meanwhile the site of the softening areas near the angle of the jaw broke down extensively with undermined but elevated skin margins, now presenting the appearance of actinomycosis as pictured in most of the books, and shown in the illustration. On the first of April the extensive pus collection in the temporal fossa was opened, giving vent to a large quantity of pus, when the cavity was found continuous (after a little manipulation through the granulation tissue) with the openings in the cheek before mentioned. Search was made for actinomyces when the first abscess was opened, but it was only some ten days after the spontaneous openings were formed in the cheek that the characteristic fishroe bodies were detected, and then only in small numbers. The question of treatment will not be touched upon here, as the case is chiefly of interest from the diagnostic point of view. Let me now read the notes of a second antecedent case.

A patient, a male, age 41 years, entered the University Hospital, stating that about six months previous to his admission to the hospital he began to

notice a slowly increasing swelling located in the right inguinal region, which extended finally from the pubes to the anterior superior iliac spine. The patient had had three years ago a swelling in the left groin, which later giving vent to pus, soundly healed. About one month after the appearance of this last swelling a physician believed he detected an abscess and opened it, evacuating a blood-stained fluid but no pus. This wound has never healed, a considerable area of skin becoming ulcerated with undermined margins, and at many points from the deeper parts a thick, dirty pus mixed with fresh blood has exuded. The scrotum was riddled with openings from which a similar discharge came. Free incision with curetting of the spongy granulation tissue was done on more than one occasion by Dr. Darling, the last one revealing the fact that the bowel was involved, a fecal fistula being present. After repeated examinations of the discharge fishroe bodies were detected and proven by the microscope to be actinomyces bovis. When the patient was discharged from the hospital six months later the fistulæ had closed, and the disease seemed to have been recovered from.

That the usual confidently expressed professional opinion that an interval operation for appendicitis presents no dangers, if infection can be avoided, and that nothing but the establishment of the diagnosis is necessary before proceeding to operate, is contradicted by the following case. For some reason the patient concealed the facts, justifying himself by saying that no one had asked him if he was a bleeder. If the type-written directions for the examination of the patients in my service had been complied with, when securing the history of this patient, the question as to serious bleeding after slight injuries would have demonstrated the existence of hemophilia.

P. H. B. Male. Aged 39 years. Came to the University Hospital for an interval operation for appendicitis. The pa-

tient gave a history of one typical attack of appendicitis, having had generalized pain localizing in the right side, vomiting, fever, and a small mass in the right groin. The duration of the attack was about two weeks. The patient gave the following family *after* history. Patient's great-grandmother, grandmother and mother always had profuse bleeding at their menstrual periods and after confinements; they also bled profusely from any small cut. One sister of the patient's mother is also a bleeder. Patient has two sisters and one brother who show the same tendency to bleed. Patient has one daughter who is a bleeder and she has to be watched constantly, having nearly bled to death on several occasions from the nasal mucous membrane. The patient himself has all his life had profuse bleeding following any small cut or injury, several months ago nearly bleeding to death from an insignificant cut upon his foot. Patient states that he has not previously bled severely from tooth extractions.

Operation. The usual McBurney muscle-splitting operation for appendectomy was performed, the bleeding being only moderate from the parietes. The appendix was soon detected beneath the cecum where it was held by rather friable adhesions; these were separated and the appendix drawn into the wound; it was amputated and invaginated by a purse string suture and a small area of the cecum showing a tendency to bleed was also invaginated. The bowel was replaced, the abdomen being perfectly dry. The wound was closed in the usual manner with catgut, the skin with silkworm-gut and horse-hair sutures. Patient was put to bed.

Twelve hours later it was noticed that patient's pulse was somewhat rapid and weaker. The patient now complained of some abdominal pain. The pulse continued to rise in frequency and grew weaker. Examination of the dressings showed them to be moderately blood

soaked. The pulse rose to 170 sixteen hours after operation and the patient then presented all the signs of serious internal hemorrhage. The wound was at once reopened by my chief of clinic, Dr. Loree, and the abdominal cavity was found to contain many ounces of fluid blood and clots. These were removed as rapidly as possible, but no definite bleeding points could be found. Gauze packing was introduced into the wound at the site where the adhesions had been broken down to liberate the appendix, thinking that the ooze from this point seemed sufficient to account for most of the bleeding. Patient was transfused subcutaneously and intravenously and given saline enema per rectum; gelatine in normal salt solution and calcium lactate were exhibited both by the mouth and the rectum. After several hours of hard work the patient began to rally, the bleeding apparently subsided and the crisis was passed.

My fifth and last case presents an interesting example of a disease process finally stimulating to rapid growth normal tissue, abnormally located. Morgagni so long ago as 1740 first demonstrated the frequency with which adrenal tissue is misplaced. Although this abnormality is most common in the solar plexus near the supra-renal body, the kidney capsule and the long spermatic veins are also not unusual sites. According to Schmorl accessory adrenals are found in the neighborhood of the adrenals in 92 per cent of all autopsies. Rossa explains their occurrence in connection with the testicle by the intimate relation of the rudiments of the sexual glands and the adrenals, both arising from the Wolffian bodies.

J. M., an American, male, aged 31 years, entered the University Hospital on account of discharging sinuses in the scrotum and an urethral discharge. His family and previous history was negative. He denies having had any venereal disease. He was well until three years

ago, when there developed on the right side of the scrotum an abscess which broke and discharged for some weeks and then healed up. He had no further trouble until September, 1905, when he developed an urethral discharge and the left testicle began to enlarge, finally reaching the size of the patient's fist; it became adherent to the scrotum, after which it opened externally.

When the patient entered the hospital the right testicle was about normal in size, but the epididymis was indurated, as was also the vas deferens. The left testicle and epididymis were represented by a swelling twice the size of a normal testicle and it was adherent to the subcutaneous tissues of the scrotum. At this time the sinuses in the perineum were curetted and a portion of the left testicle which was diseased was removed by Dr. Darling. The cavity was disinfected with carbolic acid followed by alcohol, and was packed with iodoform gauze.

Pathological examination of the curettings showed the process to be tuberculosis involving the epididymis and parenchyma of the testicle.

Repeated curettings of the sinus tracts in the perineum were done. Pathological examination of the curettings showed them to be granulation tissue with extensive epidermatization.

In March he returned to the hospital, stating that the left testicle had commenced to enlarge again three months before, and was now about the size of a goose egg; a fluctuating swelling containing about half an ounce of pus formed the upper portion of the tumor. The remainder of the diseased testicle was removed by me March 18, 1907. Pathological diagnosis was tuber-

culosis and hypernephroma (adrenal of Marchand).

These cases to one experienced in surgery present points of clinical interest worthy of careful meditation. After more than thirty-eight years of the practice of my profession, and having had my full quota of many thousands of hospital patients during that period, these cases commend themselves to me as worthy of careful consideration.

One of the chief objects I had in view in reciting the histories of these five cases will have been attained if I have suggested to a few of my hearers the paramount importance of a correct diagnosis in every case, even those which at first sight seem most simple. The art of diagnosis on one side is becoming seemingly more accurate, on the other is relegated to a second place, the operation being relied upon to clear up doubts more easily than a searching, exhaustive study of the case. Accuracy in diagnosis is within the reach of almost anyone, provided the method of exclusion be adopted. It will not do to consider the most probable explanations, but every possible condition must be carefully studied and excluded, otherwise most serious errors in diagnosis and treatment will occur. It will not suffice to have ascertained the salient points in the history of our case, have even arrived at a correct diagnosis, and have determined the proper treatment, if in that special case a careful investigation of the peculiarities of the patient under consideration have been omitted, otherwise a well nigh fatal contra-indication may exist to an otherwise eminently proper and necessary operative procedure, as exemplified by my hemophiliac case.

In alcoholic subjects head injuries are not only more dangerous to life, but are liable to be followed by a more or less marked loss of mental power.

The subcutaneous injection of physostigmin salicylate before operation is an excellent means of preventing post-operative atony of the intestine.

DIRECT TRACHEOSCOPY AS AN AID TO DIAGNOSIS*

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Detroit

The history of direct examination of the dark cavities of the body forms an interesting chapter in the development of accurate diagnosis. The underlying principle of examination through a straight tube dates from 1834, when Bonnafont devised an illuminated otoscope. Desormeaux, in 1853, published the description of a well-developed urethroscope. By the same principle, Kussmaul, in 1868, demonstrated a carcinoma of the esophagus, the first successful direct esophagoscopy. In 1879, Nitze with his cystoscope laid the foundation for cystoscopy and catheterization of the ureters as performed today. This principle of examination was not applied to the lower air passages until 1894. Rosenheim and others in performing esophagoscopy had often entered the larynx inadvertently, but to Kirstein is due the credit of recognizing the practicability of obtaining a direct view of the larynx and trachea. His method is the laryngotracheoscopy of today, and is based upon the possibility of bringing the larynx, trachea and mouth into a straight line by firm forward pressure upon the base of the tongue. The introduction of a tube through the larynx into the trachea, however, Kirstein considered highly dangerous. It remained for Killian, in 1897, to perform the first direct upper tracheoscopy with a tube, in order to remove a foreign body from the right bronchus, and to him must be given the credit for proving that a straight tube can be safely

passed through the trachea, and even into the branches of the bronchi.

Direct examination of the trachea is performed in three ways:—direct laryngotracheoscopy (Kirstein's method), direct upper tracheoscopy by means of a tube introduced through the larynx into the trachea, and direct lower tracheoscopy, the tube being introduced through a tracheotomy wound. It is to the clinical advantages of these methods that I wish briefly to call your attention today.

Direct laryngotracheoscopy is performed with the aid of a straight tube or flat spatula resting on the base of the tongue, firm forward and downward pressure of which elevates the epiglottis, affording a view of the underlying structures. Illumination is furnished by a Kirstein headlight. The success of this method depends mainly upon the mobility of the base of the tongue. In about 25 per cent of cases, Kirstein, using a flat spatula, was able to obtain a view of all structures as far as the bifurcation. In 50 per cent a partially successful examination could be secured, the posterior half of the larynx and part of the trachea being visible. In the remaining 25 per cent no view of the underlying parts was possible. With the aid of a Killian tube spatula, which allows greater movement at the base of the tongue, it is possible to examine a much higher percentage of cases successfully under cocaine. The picture obtained being a direct one, affords a much better idea of the relative position of the parts than the inverted one seen in a mirror, and at the same time the foreshortening of the latter is largely

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avoided. The posterior laryngeal wall lies before us as a flat surface, the advantage of which in diseased conditions of this region is evident. Direct laryngo-tracheoscopy is not to be considered as doing away with the usefulness of the laryngoscope. It is, rather, a supplement to the latter, its use being indicated whenever the mirror has failed to give satisfactory results. It is especially in children that this occurs, and it is in them that the direct examination is especially useful, since it is practically always successful, no matter how young the child. In examinations of the larynx for stridulous breathing or papilloma, or of the trachea for post-tracheotomy granulations or stenosis, this method is often the only one available. It is also easier to recognize paralysis in adults when the larynx is dislocated or turned on its axis, a diagnosis not always simple with the laryngoscope. Operations may be performed with its help, especially when the parts involved are the epiglottis or the posterior half of the larynx. Intratracheal conditions, such as inflammations, crust formations and tumors, are in certain cases easily seen by this method. In others for physical reasons, or on account of pathologic changes, it fails. It is especially in these latter cases, or when greater precision of observation is required, that direct upper tracheoscopy with the tube is indicated.

The instrumentarium is practically the same as for esophagoscopy, except that shorter tubes are used. After thorough cocaineization of the palate, base of the tongue, epiglottis, glottis and subglottic space, the tube is introduced with or without the aid of the tube spatula, and after cocaineization of the lower part of the trachea is passed to the bifurcation. Narcosis is generally required for this procedure in children. The diagnosis of lesions low down in the trachea such as syphilis, stenosis or tumors, is thereby rendered possible, and the treatment, either local or operative, greatly facili-

tated. But it is much more often on account of extrinsic causes that the examination of the trachea is of importance. Surrounded by numerous structures often the seat of enlargement, changes are noted in its position and form which have a bearing on diagnosis as well as prognosis. Tumors of the mediastinum, aneurysm, enlarged thyroid, and carcinoma high up in the esophagus cause changes in the form of the trachea more or less characteristic in their location and extent. The most frequent of these, especially here in Michigan, is goitre. It is important to remember that the mechanical effects of struma upon the trachea are by no means directly proportional to its size, so that dyspnea of obscure etiology should never be charged to the presence of thyroid enlargement until constriction of the lumen of the trachea is proven. When compression is present, it is important to know its position and extent and whether it is single or multiple, in order to insure the removal of the offending part at operation. This is especially true when both lobes are involved. In malignant disease of the thyroid, the knowledge whether the tumor has penetrated the trachea is decidedly pertinent in determining the plan of treatment.

The third class of cases in which the introduction of tubes is of importance is that of foreign bodies lodged in the trachea or bronchi. Direct upper bronchoscopy is only a step further than direct upper tracheoscopy, and direct lower tracheoscopy through a tracheotomy wound is most frequently performed in order to reach the bronchi, and thus becomes direct lower bronchoscopy. The removal of foreign bodies by instruments inserted through tubes has been remarkably successful, and should supersede all other methods. In nine-tenth of reported cases thus treated, removal was successfully performed. It is only when the foreign body is small and deeply situated, or when proximal

stenosis furnishes an insurmountable obstacle, that pneumotomy or bronchotomy is necessary. The mortality of foreign body cases, formerly nearly 25 per cent, has been greatly reduced.

In conclusion, we have in direct exam-

ination of the lower air passages a material aid not only to the laryngologist for examination and treatment, but also a help to the general surgeon. Direct inspection, the most valued factor for accurate diagnosis, is rendered possible by its use.

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TWO COMMON ORTHOPEDIC CAUSES OF SCIATICA*

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Detroit

Sciatica means pain in the sciatic nerve. This pain when chronic is usually caused by irritation of the nerve in the pelvis. Sciatic neuritis, if accompanying, is not usually the primary cause. Two common primary causes of sciatica are hypertrophic arthritis of the lumbar spine and sprain of a sacroiliac articulation.

The signs of hypertrophic arthritis of the spine are as follows: referred pain, of gradual onset, often in other nerves as well as in the sciatic, as for instance the anterior crural, at first in only one leg; limitation of passive mobility in the lumbar spine, more marked in flexion toward one side than toward the other; often radiographic evidence of the hypertrophy of bone and cartilage at the intervertebral disks, this hypertrophy causing, directly or through the produced inflammatory reaction, irritation of the nerve roots, and thus giving rise to the referred pain in the sciatic or

other nerves. The diagnosis depends upon the signs given above, and upon painstaking exclusion of any other possible cause, and upon favorable response to treatment. As the pain is produced by the mechanical irritation of the hypertrophied edges of bone, the reasonable principle of treatment, as in hypertrophic arthritis of any part, is local rest. The lumbar spine can be put at rest by a corset, or a leather or plaster jacket. Simple recumbency usually will not relieve the sciatic pain, because in recumbency the spine is relaxed and not held in its normal curves. If effective fixation of the spine does not greatly relieve the pain by the end of at most a week, the cause of the sciatica is probably not hypertrophic arthritis of the spine.

The signs of a sprained sacroiliac articulation are as follows: pain in the vicinity of the sacroiliac joint, usually at first of sudden onset, following an injury sustained with the body flexed on the thighs; referred sciatic pain, explained by the proximity of the sciatic nerve to the sacroiliac joint; occasionally pain

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in the coccyx; no involvement of other nerves; limitation of mobility of the spine when the motion involves the sacroiliac joint, as in the spinal motions when standing, but when the pelvis is steadied by the sitting posture and held by the surgeon's hands, the spinal motions are found much freer. The motions of the hip with the knee flexed are normal, but flexion of the thigh with the knee extended, thereby pulling through the hamstrings on the pelvis, causes much pain; tenderness over the sacroiliac joint. Diagnosis of a strained sacroiliac joint is made by the above signs, by thorough exclusion of other possible causes for the lumbago and the sciatica, and by favorable response to treatment.

The principle of treatment of a sprain of the sacroiliac joint is the same as of a sprain anywhere else, protection and rest. This principle of rest is applied to the sacroiliac joint by compression on the sides of the pelvis below the iliac crests, just above the great trochanters. Compression applied too high, i. e., at the crests, tends to spread the sacroiliac joints open. A ready method of treatment is by plaster strips applied around the back and sides in the region mentioned, first drawing the skin tight toward the median line of the back. A belt is a more permanent means. A pad over

the joint, and sometimes a complicated apparatus is needed to protect the joint sufficiently. Occasionally the joint resists all treatment until the leg is thoroughly pulled with the spine hyperextended, thus reducing a slight subluxation of the joint with an audible click, and immediate relief. A relaxation and sprain of the sacroiliac joint accounts for some of the cases of chronic disability after parturition, which normally involves for a short time a relaxation of all the pelvic articulations. Sacroiliac sprain is probably the cause also of some instances of backache in women wrongly referred to the pelvic organs. It seems reasonable to believe that undue congestion of a pelvic viscus determines congestion and weakness of the sacrosciatic joints, and vice versa.

In looking over the six instances of sciatica of spinal or sacrosciatic origin, which I have recently had the opportunity of studying throughout, I am impressed with the need for basing diagnosis on painstaking exclusion of other causes and on prompt relief of symptoms by appropriate treatment. In view of other men's large experience, it is probable that at least a half of the cases of chronic sciatica are due to hypertrophic arthritis of the spine or sacroiliac sprain.

Adrenalin With Cocain in Eye Surgery.—

S. THEOBALD, Baltimore (*Journal A. M. A.*, July 27), finds that adrenalin chlorid used with cocain in certain eye operations definitely enhances the anesthetic effect of the latter. In operations on the cornea and conjunctiva cocain alone is usually amply sufficient, but in those on the ocular muscles, the lachrymal apparatus, and for the cure of chalazion and other tarsal cysts, the conjunction of the two drugs has its advantages. In operations involving a section of the cornea, especially cataract extraction and iridectomies, with the exception of iridectomy for inflammatory glaucoma, experience has led him to be chary of the use of adrenalin. In inflammatory glaucoma cocain anesthesia alone is likely to be unsatisfac-

tory and the astringent action of adrenalin is an advantage. In operation for pterigium Theobald thinks adrenalin contraindicated, as its blanching effect renders the outlines of the growth more difficult to recognize, moreover cocain anesthesia is sufficient. Another way in which cocain is valuable, as pointed out by Dr. J. E. Colburn, is by checking hemorrhage it renders the detection of foreign bodies more easy. Though Theobald has usually employed adrenalin in full strength (1-1000), he has never seen any bad results other than those referred to. As a therapeutic agent, *per se*, in the treatment of inflammatory affections of the eye it has not proved efficacious in his hands.

HYGIENIC MEASURES IN THERAPEUTICS*

H. T. CARRIEL, M. D.

Marquette

All will admit, I think, that the use of hygienic therapeutics is somewhat neglected in routine medical practice. There are, perhaps, plausible but not excusable reasons for not giving ample time and attention to minor medical cases; minor so far as danger to life is concerned, but nevertheless, like the minor surgical cases, they form the majority of patients treated. It should be the physician's duty and greatest pleasure not only to prolong life but to foster health and physical welfare. "Physicians are the Priests of the Religion of Health." As the problems of Peace are usually more difficult and numerous than the problems of War, so the maintenance of individual physical well-being is often a more difficult and intangible problem than the prolonging of life. A wrong diagnosis is due, 90 times out of 100, not so much to the ignorance of the examiner as to the failure to make a thorough, careful, systematic examination of the patient, and the personal and family history. The failures in treatment are sometimes due, in my opinion, to partial or total disregard of hygienic measures that encourage health and indirectly remove disease.

Drugs may be the most important available means with which to fight disease from all causes. They are pre-eminent in removing some causes; are of great usefulness in combating infection; in relieving pain and promoting rest; in temporarily stimulating a lag-

ging function or depressing an over-active one; in opening up channels of excretion, thus increasing elimination and, by vaso-motor effect, relieving an inflamed or congested part. Often the value of these in aiding nature to right herself cannot be over-estimated. The specific drugs and certain serums are of course supreme in their respective fields.

In many conditions drugs are absolutely indispensable, but regular and frugal habits and the various hygienic measures are indispensable at all times—in health to keep in health; in sickness to promote health. Week in and week out, year in and year out, and in a large percentage of human ills pharmacopoeial remedies have but a small place, to say nothing of the proprietary preparations that are so convenient to prescribe and are advertised to the profession and to the laity to be specifics for many things, a means of immunity from the results of physical sins of commission and omission, and even a substitute for Mother Nature herself.

People's convictions result largely from their experiences. If their experiences have been happy, their judgment of a thing is favorable, and as there are all grades of experiences, so there result all grades of opinions concerning remedial measures. These differences extend all the way from Elbert Hubbard, who will tolerate no drugs, to the rustic old woman who says she knows there is a drug to cure each disease, and if one prescription does not cure, it is because the right medicine has not been

*Read at the annual meeting of the Upper Peninsula Medical Society, July, 1907.

used, and the proper thing to do is to try a different kind until you strike the right one. Hubbard says: "Ninety-nine people out of a hundred who go to a physician have no organic disease, but are merely suffering from some symptom of their own indiscretion, and in the vast majority of cases, they are suffering through poisoning caused by an excess of food. Coupled with this go the bad results of imperfect breathing, irregular sleep, lack of exercise, and improper use of stimulants, or holding the thought of fear, jealousy and hate. All these things, or any one of them, will in many persons cause fever, chills, cold feet, congestion and faulty elimination." He also says: "To administer drugs to a man suffering from malnutrition, caused by a desire to 'get even' and a lack of fresh air is simply to compound his troubles, shuffle his maladies, and get him ripe for the ether-cone and scalpel," and Hubbard is partly right, but the best time to go to a dentist is before there are any badly decayed teeth, and the right time to consult a physician is before there is any serious organic disease. The time is coming when the laity will go to their physicians at regular intervals to have themselves and their habits inspected. This is the right way, and physicians will become more and more hygienic specialists. Some people that have had unhappy experiences with a narrow-minded, or over busy and strictly drug prescribing type of a man with an M. D. degree have been led to the conclusion that the science of medicine begins and ends with the giving of drugs. This unfortunate and very untrue conclusion reacts unfavorably to general confidence in the medical profession. When a patient's condition is serious as to life, generally the physician gives that patient ample time and study and employs every therapeutic means of possible value at his command. The laity have noticed this and the good results, for you often hear it said that a doctor "is all right in seri-

ous sickness." In other words, a physician is all right when he gives a case attention and does all that medical science can do.

In restoring or maintaining physical well-being we must first find and remove, if possible, the cause or causes of any abnormality. This is sometimes not easy, and one may have to keep the patient for a time under observation. However, the trouble may often be traced to some physical sin of commission or omission, and sometimes it is apparently trivial. For instance, I was called to attend a six-year-old child who had been "ailing," as his mother termed it, for several months. He was whiney and thin, had little appetite and a bad complexion. I noticed the child eating sugar, and the mother admitted that he did not have much appetite for anything else, so since she thought he should eat something she allowed him to have sugar at all times. A few weeks after the continuous consumption of sugar was forbidden, and plain wholesome food substituted, the patient gained in weight, color, strength and spirits. What good results could be expected from any medication had this indiscretion through carelessness been overlooked. As a matter of fact, it was overlooked by a first-class physician who previously attended the case.

It is almost as foolish to largely neglect the hygienic therapeutic measures that may be indicated as it is to imagine that massage is the proper thing for all ailments and diseases. As foolish and narrow-minded to depend on drugs almost exclusively as it is to never consent to the use of a drug. Frugality, regularity, massage, exercise, work, recreation, rest, sleep, limited diet, forced feeding, internal and external hydrotherapy, sunlight, fresh air, mental suggestion and medicines all have their proper, though limited rational uses.

Many times it is not new therapeutic means that are needed to bring about

good results, but a better understanding and use of the means we have.

The successful use of hygienic therapeutics sometimes requires careful detailed directions; observing the patient, to modify these directions or to see that they are understood and carried out. For instance, it is one thing to tell, in an off-hand manner, a patient with nervous dyspepsia "to be careful of his diet," and quite another to teach him not solely what he should eat, but how he should eat, and how to conduct himself before and after, and even sometimes between meals. The poor physical condition of a horse that habitually bolts its grain is corrected successfully by an ingenious device that allows oats to be taken only so fast. Some people are like this kind of a horse, only worse. They go to meals out of breath, hot, tired or excited, bolt or semi-bolt their food, and right after eating begin doing something strenuous, and sooner or later suffer more or less from indigestion. We are all familiar with the reasons for this suffering. I have had several cases permanently relieved by proper correction of these faults. If a patient is physically or nervously exhausted at meal time, it is sometimes marvelous how a short rest, relaxed on the flat of the back, will temporarily revive the strength and feelings. Appropriate medication to regulate bowels and correct the gastric and intestinal catarrh is, of course, indicated temporarily, but we must get at the etiologic factors to accomplish good and permanent results.

During the middle of last winter I saw a chronic consumptive with an acute bronchitis. She complained that she easily caught cold, had practically no appetite and "felt dragged out" most of the time. I believe that in a very large measure the open air treatment of tuberculosis helps heal the lungs through the stomach by greatly increasing the capacity of the patient to take and assimilate food without repulsion, nausea or

digestive disturbances. To be brief, this patient began to sleep with a blind fresh air chute affair from the head of her bed to an open window, such as you have all seen. She also took a short afternoon rest in this bed, where her head was in direct contact with the out-of-door air. She was compelled to continue her housework and care of her children, but it was not long before she felt more rested and refreshed on rising in the morning, appetite improved, and eggs and milk were now easily taken between meals. She has been free from colds, and has gained in weight and strength.

Among my first patients who helped arouse my interest in hygienic therapeutics were three children of a man employed by the Colorado Fuel and Iron Company. These children had acute sore throats, bronchitis or digestive disturbances most of the time. Their mother continually dosed them with medicine. Finally, I, as the local company's surgeon and dispenser of medicines, declined to furnish any more, since she had not followed my general hygienic directions. Once again I explained to her that she was ruining the present and future health of the children by keeping the house stuffy and hot, by dressing them over-warm, by tickling their appetites with fancy cooking, and was making greenhouse plants of them by not allowing them to play and romp out of doors in the snow all winter, except on rare and brief occasions. And I mentioned that a dog or a horse would die under the same conditions. My general directions are now carried out, and the last time I saw these children they were anything but anaemic and soft, and as their damp clothes and stockings were changed as soon as they came home after coasting, et cetera, there was now a reduced but more rational demand for medicine.

Physical culture is good, but not so universally good as the physical culture magazines would make believe. For

some persons it is contra-indicated, yet for the majority, with sedentary habits, a system that combines recreation and exercise, without wear and tear on a probably already overworked nervous system, is beneficial. Many a physical culture enthusiast reaches a point where he begins to feel languid, irritable and tires easily—these first symptoms of exhausted nerve cell storage batteries make their appearance. It is folly to develop the muscular, vascular and respiratory system at the expense of the nervous system. The hygiene of this system should not be forgotten.

And so it is, everything has its uses and limitations, and who but the regular physician can discriminate and prescribe?

People seldom die from overwork, but do often die from underrest and relaxation of the body or the worry center.

Now, for fear I forget, let me say that the sins of the mind—fear, jealousy, worry, and hate—so keep the nervous cell storage batteries exhausted or perverted that health and good spirits are impossible. Right thinking and charitable feeling with proper care of the body are a strong combination for health. Take an animal free from organic disease, give it kind treatment, and the best of care, and it thrives. Take a woman, or a man, for that matter, free from organic disease, give her kind treatment and the best of physical care, the "rest cure" if indicated, and if the patient is guilty of unhealthy thoughts and fears, you get no good results, nor will you get them unless the surroundings, associates (or nurse, as the case may be) or mental suggestion correct the mental perversion.

I want to mention something that has time and again proven almost a specific

for the troubles and ill-feelings of housewives, who plod along from morning to night, are always physically tired and nervously worn out, and seem to have no time for recreation, out-door life or rest. It helps matters if these women would plan their work ahead, hustle and do the heavy or disagreeable work in the morning and get their principal meal at noon. Then in the early afternoon, when the bulk of the day's work is done, undress, take a luke-warm sponge bath, lie flat down in bed and rest for an hour or more. After this, dress up and go out of doors or confine themselves to light work they rather enjoy doing, and so vary the day; they find they have some recreation, do their work unusually well, feel more rested and have better health and spirits. Likewise, many business men have too much business, too much monotony and too little health.

It is not necessary for me to mention the value of good general nursing in acute serious illnesses.

Hygienic therapeutics are admitted specifics for some serious pathological conditions—the combination of out-door living, rest and forced feeding for tuberculosis; rest, excluded but pleasant surroundings, mental suggestion and forced feeding in neurathenia—is there any reason why some combination of these and other remedial or healthful measures that correct an evil or supply a deficiency are not specifics for a multitude of people who are like a plant that does not thrive for the want of something necessary to its health development.

In conclusion, the intelligent gardener can usually tell whether his plants' unthriftiness calls for paris green, more or less water, sunshine or soil. The intelligent, broad-minded physician will give the same solicitous care to human plants.

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THE PROFESSIONAL SECRET AND THE LAWS.*

CHARLES L. GIRARD, M. D.,

Escanaba

"I swear by Apollo, the Physician, and Esculapius, and Health and all Heal, and all the Gods and Goddesses that, according to my ability and judgment, I will keep the oath, and this stipulation. . . In whatever house I enter . . . Whatever, in my connection with my Professional Practice, or not in connection with it, I see or hear in the life of men which ought not be spoken, I will not divulge, reckoning all such should be kept secret. . . While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and practice of the Art, respected by all men in all times; but should I trespass and violate this Oath, may the reverse be my lot."

So reads the Hippocratic Oath, with reference to the professional secret which Hippocrates exacted of his disciples, and which has bound all our professional ancestors until it has reached our immediate progenitors with no material changes, and unviolated by thousands upon thousands of individuals of different characters, pertaining to all climes and to all ages, through so many centuries, and in some instances, under dire stress. The Gods certainly heard it with favor and manifested their approbation by granting to the faithful observers thereof "the practice of the art respected by all men in all times." Indeed, the beginning of the decline of the former respect of the public towards the medical profession almost coincides with the time when, under the whip of the law, medical men were forced to relax somewhat of their former secrecy. I have said our immediate medical progenitors, for it

was not so very long ago when the antique ceremony of administering the Hippocratic Oath to the new graduate, previous to conferring upon him his diploma, was still in practice, and though this time honored custom has, with many others, been abandoned as antiquated, the principles embodied in it have been preserved in the Code of Ethics of the American Medical Association. But even this is fast becoming obsolete, and by many of us would be blithely relegated to the ever increasing scrap pile of fogysm.

Still, it cannot be denied that this oath of secrecy had its foundation, not only upon the strictest principles of honor, but also upon the soundest policy, for, possessed of the innermost secrets of the individuals and families, a physician's discretion is, along with ability and probity, his highest qualification, and that which enables him to command confidence and implicit trust; upon these rests his success; to win them his highest aim; they are the brightest jewels of his professional crown. If then this secrecy is so important and based on such worthy motives, why should it be lightly dealt and tampered with by the laws, except for the most pressing reasons? However, it has been for ages disregarded by the common law, and still remains so; but reasons of public policy have compelled the several states to provide for it a certain amount of protection by enacting special statutes to this effect.

In Michigan the law reads thus: "No person duly authorized to practice physic

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or surgery shall be allowed to disclose any information which he may have acquired in attending any patient in his professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or to do any act for him as a surgeon." (Howells stat. 7516.) This privilege includes both the secrecy against publication and the right to control the introduction in evidence of such information or knowledge communicated to, or possessed by the physician; the latter right exists, although the former has ceased to be of any benefit. For instance, the party may have disclosed to a third person all that he has to his physician. Now, while his admissions may be proved in a proper manner by such third person, they cannot be proved by the physician against the objection of the party. ('Supreme court; Breisenmeister vs. K. of P.)

From this privilege, however, are excepted the communications relative to criminal abortion, and this, for the avowed purpose of facilitating the convictions which are so difficult to obtain in that class of cases. As a reinforcement of this, there is even now, pending in the Michigan Legislature, a bill for an additional statute to the effect of making it a misdemeanor to propose to a physician to perform such an abortion. Now, gentlemen, in the latter instance, would you really think it your duty to betray the misguided mother who, broken in health and spirit by the manifold cares of an already too exuberant family, or the anguish-crazed young girl, who has been the victim of her carefully nurtured ignorance, when they come to tempt you to an act the full criminality of which they hardly realize, or would you only instruct them, and recall to them a better sense of their moral obligations? Should you adopt the latter course, what becomes of the utility of this law? Unless, indeed, it would be provided also that the widest publicity

should be given to it, so as to scare these people off their criminal intents. But usually nobody but the legislators and the lawyers know anything about the addition of any new law to our statutes, and still we are constantly reminded that "ignorance of the law excuses no one." Therefore, these two measures are much more honorable in their intent than shrewd in their concept, for the real difficulty to overcome lays in the defective machinery of the law itself. Let the legislators curb their pettifogging proclivities; let them rid their code of procedure from their medieval traditions and modern red tape, and convictions of real criminals shall become possible, and people in the audience, endowed with common sense, but unshakled by the oath that binds the juror to follow the instructions of the court, will no more be sorely tempted to cry aloud the old Scotch verdict: "Not proven but guilty."

So much for the criminal laws with relation to the professional secret. Now, as to the health laws: When modern progress in sanitary science devised certain quarantine and other regulations as the proper means to combat contagious diseases, it was judged necessary by the state to give countenance and support to these measures by making the report of such diseases obligatory. And upon whose shoulders should this responsibility land the heaviest, if not the physician's, bound by his oath of secrecy? But the oath having been formulated for the benefit of humanity, it naturally follows that when the greater good of humanity required it, the letter ought to give way to the spirit, and the part be sacrificed to save the whole; therefore, the physician's conscience absolved him. Nor did he reckon that his obedience was likely to cost him the affections of as many of his patients as were so ignorant and prejudiced as to mistake his motives and regard as a sort of spy the man they were accustomed to welcome as a minister of con-

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solation. The law was just and wise and that was sufficient to him. This was nevertheless a serious blow struck at the professional secret; but more were to come.

As it was, this victory of the law over the Hippocratic Oath has proven to be far from an unmixed blessing; for taking no consideration of the ignorance of the public, it ran contrary to popular prejudice and has shared the fate of all other laws not backed by public opinion; that is, they become more conspicuous in the breaking than in the observance; and though the situation has been greatly improved in these latter years, there are still many, too many people of the ignorant class who will run the greatest risks of the lives of their children rather than call upon the physician who, they well know, is sure to report the case and have the house placarded and quarantined; such concealment increasing the danger of the spreading of the contagion and defeating thereby the very end to which the law owes its existence.

More insidious and no less dangerous was the attack upon the professional secret made by the statute requiring the certificates of death; for the cormorants who parade under the name of insurance men have seized upon this new opportunity. Ever on the alert to find a pretext for evading their obligations, they haunt the registration bureau to filch information wrested by the law from the family physician, and which ought to remain strictly confidential and for the sole use of the health authorities. This certainly ought to be looked into and the practice stopped. These people carry their audacity even to the point of asking the family physician about diseases and injuries suffered by their clients, or the examiner himself if he happens to have treated the applicant on former occasions. I do not hesitate to say that, unless the examiner can find by present actual examination traces of disease or injury, he cannot mention such things (unless the

applicant consents to it) without a serious breach of duty. The birth registers, not being provided with any protection against their being consulted indiscriminately by scandal mongers and other persons mischievously inclined, are also open to criticism. These two statutes, as they exist today, may be considered as defective in so far as they are apt to cause unnecessary hardships or cast unmerited reproach, and they ought to be amended in such a way as to make the officials who keep these records subjected to the same restrictions as to secrecy as govern the physicians themselves. We hope that in expressing these opinions we will not be misunderstood. We have reference only to the possible abuse arising from the present wording of these statutes; our desire is to amend, not to suppress them.

We cannot close this paper before bringing to your notice a rumor of a bill to be introduced at some future time, wherein it shall be made a misdemeanor not to report cases of venereal diseases. If this blow at the Hippocratic Oath ever comes to have its full effect, the professional secret will be done away with altogether, and physicians shall be held in the future by no other bond than that of any ordinary gentleman who is desirous of doing honor to his title as such. We have seen how the tampering with the professional secret has failed to produce all the good that was expected of it because of an absence of knowledge of mankind and his failings, which are ignorance and egotism, the father and mother of prejudice. So then, let not the same error be repeated in the coming struggle of the health laws against venereal diseases that was committed in the case of common affections, that is: legislating first and educating afterwards, as has been done so far. If the public is not previously enlightened by a regular and systematic campaign of education about the baneful effects of venereal diseases and the laws of sexual life, we

foresee manifold troubles resulting from the projected legislation, among which unpleasant relations between physician and patient shall not be the least. And to be brief, it is greatly to be feared that the already too great disinclination of such patients about seeking timely treatment, will be increased ten-fold, and may create a greater havoc in the community

than that which it strives to abolish.

In conclusion, we would deprecate the passing of the proposed law for the present and until such time as by concerted and perseverent action the profession shall have succeeded in educating our citizens into accepting it as a boon to mankind instead of resenting it as a fresh attempt on their liberty.

THE PREPARATION OF CATGUT.*

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Marquette

I have in the past encountered various difficulties in the successful preparation of good suture material, and a short article on this subject might be interesting and profitable to you all. It is not my intention to have my name associated with any particular method of preparing catgut.

About twenty-one years ago, while a student, Senn, then traveling in Europe, found that Kocher of Berne was obliged to abandon catgut, owing to infection from anthrax in several of his operative cases. On hearing this, Christian Fenger discontinued its use at once and used silk instead. In 1890, I induced Fenger to again use catgut after it had been boiled in alcohol one hour a day for three consecutive days. No bacteriologic examinations of this gut were made, but the continued use of it showed it to be quite reliable.

Senn, in 1905, advocated the Claudius method of preparation and it was soon adopted by many surgeons in this country. The Claudius method is to immerse

the gut for 12 hours in ether, then in one per cent solution each of iodine and potassium iodide in 80 per cent alcohol. Preserve in this solution.

I prepared 1100 feet of gut by this method and found that the solution soon destroyed its tensile strength, in fact it soon became absolutely worthless as a suture material, despite the fact that it remained perfectly sterile.

Dr. Alex V. Moschowitz of the Mount Sinai Hospital of New York found by not immersing the gut in ether for twelve hours but, by placing it in the iodine-potassium iodide solution for eight days and then keeping it in a dry sterilized bottle, well sealed, it retains its tensile strength. I have here some of the Senn-Claudius gut prepared by a reliable surgical supply house. You will notice that this one per cent solution of iodine in 80 per cent grain alcohol stains the operator's fingers as well as the towels and sponges used on the operating table. Another objectionable feature is that after removal from the glass rod or spool it is necessary to run it through your fingers several

*Read at the annual meeting of the Upper Peninsula Medical Society, Menominee, July, 1907.

times to straighten it, as it is impossible to use it without removing the numerous coils and kinks. It appears to me this undue handling with the naked hand has a tendency to reinfect it, although Dr. Moschowitz has demonstrated that iodized gut can not be infected. The only serious draw-back is the loss of tensile strength, as you see slight tension breaks the strand I have in my hand. The dry iodized gut is very stiff and wiry, and is difficult to handle. Owing to the fact that iodized gut has been proven by bacteriologists and surgeons to be sterile as well as antiseptic, and practically non-infectible, I was anxious to use suture material impregnated with iodine.

Dr. Willard Bartlett of St. Louis, published his method of preparing the so-called Bartlett gut in the *Journal of the American Medical Association*, April 21, 1906. In this article he says: "So many prominent surgeons have adopted my suggestions for the preparation of catgut that I wish to describe methods which make the procedure vastly simple in its application, and which at the same time remove any element of uncertainty regarding the results likely to be obtained." Shortly after this article was published I began to sterilize catgut by this method, and I found that it was absolutely impossible to prepare suture material by the Bartlett process. The resultant gut was very brittle and much of it was broken into short pieces when I removed it from the oil. Out of 1500 feet of gut, I did not find more than one dozen 30-inch strands that were usable. The tensile strength of these few strands was not what it ought to have been. I wish to say that 300 feet of gut were prepared each time and all five trials were failures. The catgut was purchased from five different instrument houses located in Chi-

cago, Milwaukee, Grand Rapids, Detroit and Cincinnati; one-half of the catgut was the polished and the balance of the unsandpapered variety. It was the best German gut to be found on the market. I was finally advised to bake the gut in an oven to drive off the water it contains and then follow the Bartlett method.

This catgut which I am now showing was prepared in the following manner:

Each strand of ten feet is cut in four lengths, each 30-inch length is then coiled and strung on a string. It is then baked in an oven for fifteen minutes at a temperature of 240° F., and then transferred to the jar of liquid petrolatum heated to 212° for four hours and one hour at 300° F. The temperature is then allowed to return to 212° F. and the catgut is then pressed for a few moments between sterile towels. It is then placed in wide-mouthed bottles filled with a one per cent solution of iodine crystals in Columbian spirits. Examination will show that it is very soft and pliable, it has great tensile strength, combined with absolute aseptic and antiseptic properties which with its resistant absorbability render it an ideal suture material.

It will be noticed that the essential part of the process that insures the success of this method, is to bake the gut in an oven before placing it in the oil. Dr. Bartlett does not mention this part of the method in his article and I know that it is impossible to follow the directions that he so generously gives to the medical profession and obtain suture material fit for use. Possibly in some future publication he may enlighten us how the DeWitt-Sukens Company of St. Louis successfully prepares a very good quality of catgut under the trade mark, "The Bartlett Process."

If a foreign body in a child's ear cannot be removed by syringing, it is best, as a rule, to administer a general anesthetic before the use of

instruments for its extraction. Few children will keep quiet enough to permit of this being done without the risk of injury to the meatus or drum.

A RARE CASE OF ACCESSORY RIB

HUGO A. FREUND, M. D.

Detroit.

Rare anatomical specimens of malformations, faulty development, or accessory parts, are reported every now and then from large pathological institutes or from dissecting rooms. For many years Wenzel Gruber conducted a section in *Virchow's Archives* where he published accounts of some remarkable anatomical curiosities that he had, from time to time, collected from the large material, dissected in St. Petersburg. Though unusual specimens are reported from every system of the body, probably none claim more oddities than the skeleton. The bony framework, both from its embryology and comparative morphology, permits of many anomalous formations. Especially is this true of the thoracic cage where reversions and clefts are frequently seen.

Perhaps the most common costal anomaly is the supernumary rib, either cervical or lumbar. The former is sometimes of clinical significance, in that it is mistaken for other structures or it gives the individual a peculiar appearance. There are innumerable reports of accessory ribs covering series diagnosed during life, found at operation, or met with on the dissecting table.

Next in importance come cleft ribs, of which there are many instances on record. These clefts extend a variable distance back from the sternum and the two ends articulate separately. Pepper records a case of bifurcation of the fourth rib on the right side, two and one-half inches from the sternum. Stru-

thers cites several cases of bifurcated ribs with more than one articulation with the sternum.

Of cases of union between two ribs those in which there is a flat plate (with perhaps only a slight groove) are occasionally seen. Scott reports a rare instance of a bony outgrowth extending from one rib, running to and uniting with the other by distinct articulation.

The anomaly that I wish to report differs from any that I have been able to find mentioned in the literature excepting one—a somewhat similar case reported by Gruber in *Virchow's Archives*. In this case the anatomical specimen was that of a deeply forked third rib on the left side, which had no counterpart on the right. It had no articular surfaces. (The text shows a fair picture of his specimen.)

What adds interest to the case here reported is that it was disclosed during life by a radiograph made for the purpose of detecting early pulmonary tuberculosis.

The patient in whom this anomaly is present is a female aged twenty-four. Her family history is negative in every regard. There have been no anatomical peculiarities in the family nor in any of the collateral branches so far as she is aware. She had the ordinary diseases of childhood in a mild form, but has been in excellent health up to the present time.

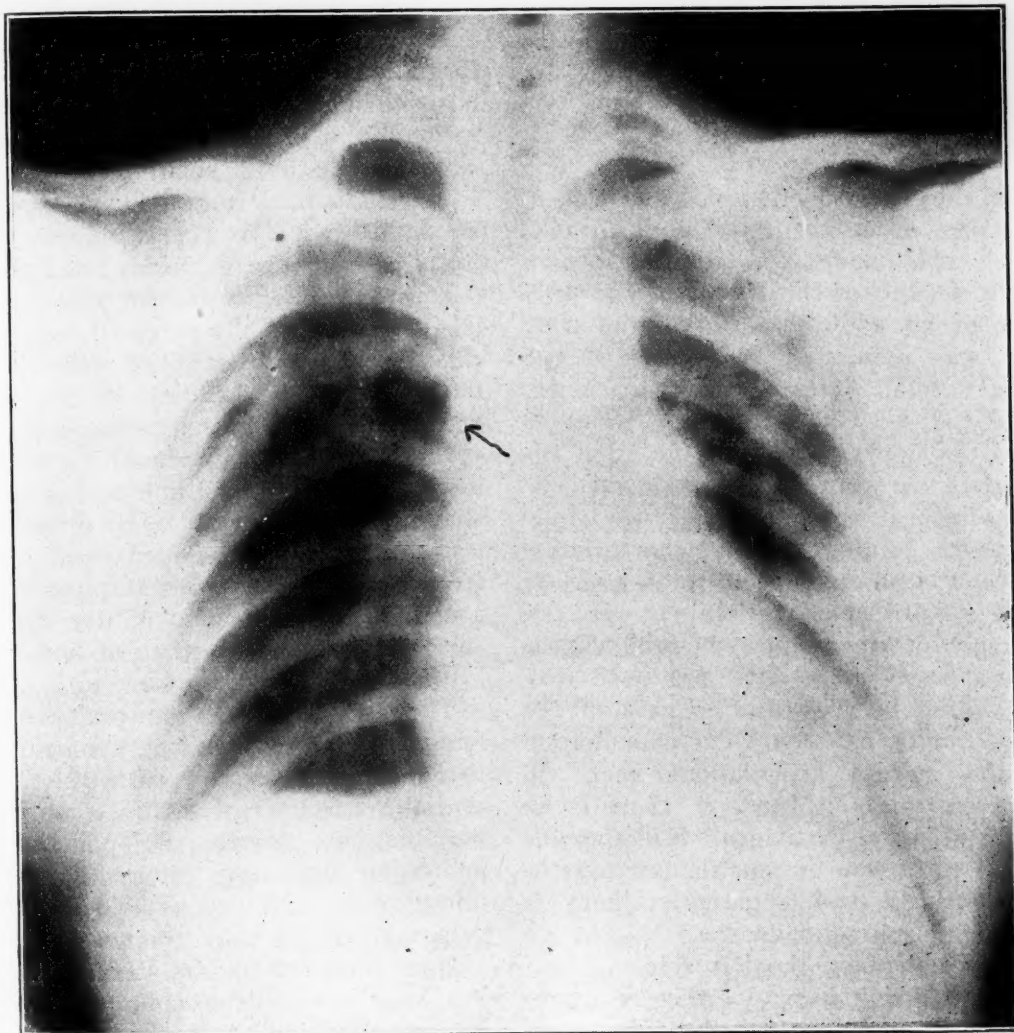
On December 18th she complained of sharp pains in the middle of the back, mostly on the left side, aggravated by deep breathing. One week previously she had experienced some slight pain on that side but paid little attention to it. At the time of examination there were sharp

From the clinic of Internal Medicine, University of Michigan, George Dock, M. D., Director.

stinging pains which became severer on the slightest movement of the patient. She had felt weak all the morning and somewhat chilly. Ate no dinner. Temperature 100° F., pulse 103, respiration 23(?).

Face was flushed; eyes bright. Accessory muscles moved on breathing. Mucous membranes

column, rising higher in the mid-scapular line. There was no paravertebral dulness. The breath sounds were distant but the harsh vesicular breathing was clearly audible. A to and fro rub was heard, loudest just inside the angle of the scapula. The spoken and whispered voice sounds were inaudible low down. They were not in-



were negative. Thorax was well formed, of normal length and good depth. Motion of left side somewhat limited. No bulging of interspaces. Litten shadow about three centimeters on the right side; absent on the left. Traube's space was obliterated. Dulness in the flanks extended to the seventh rib, and around to the vertebral

creased above the line of dulness.

Dry cups were applied and large doses of salol administered. She was put upon liquid diet and an ice-cap applied. The patient rapidly improved and signs of the effusion soon disappeared.

As soon as opportunity permitted a careful examination of the chest was made. The left side

expanded less than the right. The left apex was about one-half centimeter lower than the right and the percussion note slightly higher pitched. The vesicular breathing was markedly diminished and the expiration was prolonged. The whispered voice was better heard on the left side down to the first interspace. A few crepitant supra-clavicular fossa.

and sub-crepitant rales were heard in the left

There was a slight cough occurring mostly in the morning. No other symptoms. The sputum was copious in amount and contained many alveolar and epithelial cells. No tubercle bacilli found after several examinations.

At this time the patient was able to be taken from her room and a radiograph was made. In addition to the slight density of the left apex, the presence of an additional rib on the right side was seen. All the pairs of ribs were normally attached and articulated with the vertebral column. Springing from the upper surface of the sixth rib, about seven centimeters from the median line, a small protuberance could be seen. Joining this by what appears to be a separate and distinct articular surface, an accessory rib springs and courses downwards and around the thorax between the fifth and sixth ribs. Its course in the anterior part of the body cannot be seen. On examination of the sternal articulations each rib joins separately. Moreover, there is no fusion of costal cartilages. Still the ribs on the right side lie much closer together anteriorly and apparently there is one more costochondrosternal joint on the right than on the left side.

The left side has no structure corresponding to the extra rib. Moreover,

there are twelve distinct ribs on the left and thirteen on the right. This can be easily demonstrated on the radiograph or on the patient herself, where the ribs are easily counted. On palpation of the back, on the right side just within the angle of the scapula, a small protuberance can be felt, but the extra rib coursing from it is not palpable.

It would be difficult to explain the formation of this anomaly on any other basis than that of a cleft. Early in the formation of the sixth rib when it existed merely as a small protuberance, a longitudinal cleft must have occurred which extended as the development of the rib proceeded. Finally, when ossification set in, the divided rib took its position between the true fifth and sixth ribs. Whether a simple diarthrosis exists between the head of the extra rib and the tubercle arising from the sixth rib, can only be conjectured. From the distinctness of its outline and from its shape it would appear as if a ball and socket joint had developed to allow for freedom of motion with respiration, inasmuch as the direction of the articular surfaces differs from that of any other in the thoracic cage.

The anomaly is an unusual one and finds no exact counterpart in medical literature. It is only with the X-ray that the diagnosis of such a condition is possible ante-mortem, for physical examination does not often lead us so minutely into the close inspection and palpation of the bony framework.

I am indebted to Mr. Vernon J. Willey for the excellent radiograph which he placed at my disposal.

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- (4) Sandefort—*Museum Anatomicum*, Plate XLVII.
- (5) MacDonnell—*Journal of Anatomy and Physiology*, xx., p. 405.
- (6) Struthers—*Journal of Anatomy and Physiology*, ix., p. 17. "Variations of Vertebrae and Ribs in Man."

The Journal of the Michigan State Medical Society

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OCTOBER

Editorial

Medical Organization and the Insurance Companies. Medical organization has accomplished much during the last five years, but we are, nevertheless, just beginning to realize the immense influence which a united profession can exert, provided only that the influence be directed toward things which are right and just.

When certain of the old line life insurance companies, in their campaign of economy, reduced the fee for examinations from \$5.00 to \$3.00, an undoubted injustice was done, not only to the physicians who make the examinations, but also to the policy holders of the companies. Doubtless the ordinary examiner will make as complete and thorough an examination for the lower fee as for the higher, providing he consent to continue—an argument which the companies have repeatedly used—but that, it seems to us, is not the point. The reduction in the fee results and has resulted in the resignation of good men all over the country and the employment in their places of men who are inferior, men at least who put a lower valuation on their services, which in ninety per cent of the instances means inferior men.

That the companies should dictate the fees which the profession shall receive naturally aroused much indignation, and resulted in a protest so widespread that

several companies have apparently been convinced of the injustice, or perhaps poor policy, of the reduction and have returned to the old schedule. Recently the Equitable Assurance of New York, the Union Central of Cincinnati, the Fidelity Mutual of Philadelphia, and the Mutual Life of New York, have restored the old fees. The letter of the Mutual Life is as follows:

New York, July 23, 1907.

Circular No. 88.

Dear Doctor:—I am glad to announce to the Medical Examiners of the Company that on and after Aug. 1, 1907, the company will pay a fee of \$5 for each completed examination for new insurance, irrespective of the amount of insurance applied for.

This has been rendered possible by rigid economy in other directions, whereby a saving in the expense of obtaining new business has been effected of sufficient size to warrant this step.

All extra allowances for mileage, obtaining additional information, urine, etc., will be abolished, beginning August 1. The fee for a microscopical examination of the urine will be \$5, as heretofore, but this will only be made when directly called for by the company.

The fee for a certificate of health for the restoration of a lapsed policy will be \$2 unless a full examination is called for, in which case it will be \$5.

Very truly yours,
BANDRETH SYMONDS, M. D.,
Medical Director.

In order that our readers may discriminate between \$5.00 and \$3.00 companies, the following list of \$5.00 companies, doing business in Michigan, is appended. This list has been compiled from good authority, but we shall be glad to make a note of any errors which may exist:

Aetna, Hartford.
Berkshire, Pittsfield.
Connecticut Mutual, Hartford.
Equitable Assurance, New York.
Fidelity Mutual, Philadelphia.

Manhattan, New York.
 Massachusetts Mutual, Springfield.
 Mutual, New York.
 Mutual Benefit, Newark.
 National, Montpelier.
 New England Mutual, Boston.
 Northwestern Mutual, Milwaukee.
 Pacific Mutual, San Francisco.
 Penn Mutual, Philadelphia.
 Phoenix Mutual, Hartford.
 Provident Life and Trust, Philadelphia.
 Reliance Life, Pittsburg.
 State Life, Indianapolis.
 State Mutual, Worcester.
 Sun Life Assurance, Montreal.
 Union Central, Cincinnati.
 Union Mutual, Portland, Me.
 United States, New York.



Repeaters in medical literature are common to a certain class of medical journals, which take no pains to reserve their pages for original or exclusive articles. By *repeaters* we mean the publication of a paper in numerous journals, thus assuring a wide circulation. Physicians of skill and wide reputation have occasionally indulged in this practice, but those who are most careful avoid it. Moreover, the best medical publications will print articles only when assured that they are not to appear or have not appeared in other journals. Even with this restriction there is no dearth of medical writings. Every article presenting original matter is indexed in the library of the Surgeon-General's office at Washington. There it is best known who are the men perpetrating repeaters and which are the journals fostering them. Editors who look over their exchanges carefully have also the same knowledge.

There is probably no intrinsic wrong in multiple publication of one article; if a man desires the advertisement, he undoubtedly has a right to it. But intrinsic right and wrong do not rule men's opinions and there is a feeling abroad

that the practice of repeating is not of a high moral order. Those who are guilty of it sometimes have difficulty in offering their wares to the best periodicals. On the part of editors, great caution is observed and much work is necessitated in keeping their pages free from such repeaters. Therefore, it would seem that, for the sake of both the author and the editor, this undesirable habit of repeating should be abated.



Apropos of the optometry bill which was introduced in the Michigan legislature last spring, and which was not reported out by the Committee on Public Health, the action of Governor Hughes, of New York, in vetoing a similar bill is of special interest. As in our own state, the matter had been up at successive sessions in New York and the bill defeated either in committee or on the floor. This year, however, despite the strenuous objection of the legislative committee of the state medical society, the optometry bill was passed. Governor Hughes, however, vetoed the bill, and in doing so, filed the following memorandum:

It is the intent of this bill that the board of examiners in optometry, to be appointed by the Board of Regents, shall be selected from those nominated by the Optical Society. It is also provided that the prescribed course of professional study in schools of optometry shall be had in such schools as maintain a standard satisfactory to the board of examiners. These provisions remove from the jurisdiction of the Board of Regents matters which it is important should be placed in their control. If the practice of optometry is to have the recognition and regulation contemplated by this bill the appointment of examiners should not be limited to those nominated by a particular society, and the determination of the standards of professional schools should be unequivocally left to the proper state authority. This is the policy established by the law enacted this year regulating the practice of

medicine, and in my judgment it is unwise in legislation along similar lines to adopt a different principle.

(Signed.)

CHARLES E. HUGHES.



The Surgeons of Grand Rapids are to be congratulated upon the action taken, at a recent meeting, to abolish the pernicious practice of the division of fees. Likewise are the physicians and the public as well to be congratulated. We are not aware that this practice has been any more prevalent in the second city of the state than elsewhere, but that it exists there, and exists to the extent requiring forceful means for its checking, is evident from the action taken.

The following letter has been received:

Grand Rapids, Sept. 14, 1907.

To the Editor:

At a meeting of about twenty of the leading surgeons of this city, held in the Morton House, Sept. 6, 1907, the following resolution was adopted and signed by every person present:

"We, the undersigned, practitioners of surgery, in the city of Grand Rapids, do hereby mutually agree that in the matter of operative fees, we will each and severally make our own charge to the patient, leaving to the physician who refers the patient the privilege of determining his own fees, with the understanding that the patient shall definitely know the charges of the operating surgeon and all the physicians concerned. We do also hereby agree that there will be no percentage, division or rebate of the operating surgeons' fee to the physician referring the patient."

Five hundred copies of the above were ordered printed for distribution by each surgeon to his physi-

cian friends for whom he is accustomed to operate. Printed copies, suitable for framing and hanging in the office, were also ordered. This expresses our opinion and places the surgeons of Grand Rapids on record regarding their position on the "Division of Fees Question."

A report of this meeting was ordered sent to the Journal of our State Society and also to the Journal of the American Medical Association.

Respectfully yours,

F. A. WARNSHUIS,

Secretary of the Meeting

Book Notices

Modern Medicine: Its Theory and Practice. Edited by William Osler, M. D. Assisted by Thomas McCrea, M. D. In seven octavo volumes of about 1,000 pages each; illustrated. Volume II, 828 pages, \$6.00 net. Lea Brothers & Co., Philadelphia, 1907.

The second volume of this splendid system maintains the high standard set by the first, which was reviewed in our June issue. The present volume covers the infectious diseases in 39 chapters, each subject being treated by a well known authority on the subject.

Hektoen writes an introduction of 70 pages covering the strictly microparasitic infections. The agents of infection, their manner of entering the body, their elimination, and their effect upon metabolism are some of the subjects fully discussed. Hektoen then takes up immunity and serum therapy, setting forth these difficult problems in a particularly clear and concise manner.

McCrae, the associate editor, writes five chapters, covering 160 pages, on typhoid fever and one chapter each on typhus and relapsing fever. The discussion of typhoid is complete and eminently practical. Particular attention is given to prophylaxis and treatment. The stamping out of this disease is one of the great tasks now before the profession and every physician practicing where typhoid prevails, should read the forceful sections which McCrae has written on this subject. It is no exaggeration to say that these

160 pages form the best monograph in English on typhoid.

The section on small pox is by Councilman, in whose laboratories most important studies were made during the Massachusetts epidemics of 1901 and 1902. There are excellent illustrations showing the pathology and the various stages of pustulation.

The chapter on vaccination by Doek is especially interesting and valuable. The results which have followed its use are set forth in a most convincing manner; even Fra Elbertus could not but be moved by the array of facts and statistics. The article contains many important practical points.

Few men in America have had greater experience with scarlet fever than McCollom, whose chapter on the subject as an excellent one. "The prognosis depends very considerably on the complications and not on the disease itself, except in the fulminating type;" hence particular attention has been given to the treatment of these complications. The section on diphtheria is also from the pen of McCollom. We wish that the chart on page 431 could be reproduced in every newspaper in America. It shows the mortality in the Boston City Hospital from 1888 to 1894, when no antitoxin was given—37 to 49 per cent—against 8 to 14 per cent during the antitoxin years of 1895 to 1904.

The two chapters on lobar pneumonia by Musser and Norris are among the best in the book.

Acute rheumatism from the pen of Poynton of London is included among the infectious diseases. The newer work on etiology is fully treated.

James Carroll contributes a most interesting chapter on yellow fever, and Calvert one on plague.

Other chapters are Measles, Rubella, the Fourth Disease, and Erythema Infectiosum, Whooping Cough and Mumps by Ruhrah; Influenza by Lord; Dengue by Coleman; Erysipelas, by Anders; Septicemia and Pyemia by Pearce; Cholera by Dunbar; and Dysentery by Shiga.

If the completed work fulfills the promise of the first two volumes, it will indeed be a great addition to medical literature.

The Principles and Practice of Dermatology. By William Allen Pusey, A. M., M. D., Professor of Dermatology in the University of Illinois. Octavo, pp. 1021; 367 illustrations; cloth, \$6.00. D. Appleton & Co., New York, 1907.

For a number of years Pusey has been a teacher of recognized authority and a favorite with all who have been fortunate enough to attend his lectures and clinics. On account of his early, thorough and enthusiastic work on Radiotherapy and Roentgentherapy, he has become one of the best known dermatologists of the country. The appearance of his book is therefore of particular interest.

The work opens with a section of 165 pages on the principles of dermatology. Anatomy and physiology are fully treated, and etiology, pathology, symptomology, diagnosis, treatment, and classification receive due attention. The chapter on pathology is especially good and that on treatment sets forth the latest advances, even to a consideration of Wright's opsonic method. Numerous prescriptions, found useful by the author, are given. This section on treatment comprises over 50 pages.

Regarding classification, the author says: "Given, approximately, 300 diseases of more or less uncertain pathology; arrange them in groups according to their pathological characteristics. It goes without saying that no one has been able under these conditions to produce a perfectly satisfactory solution of the problem." The author closely follows Unna's classification.

The major portion of the work deals with the Practice of Dermatology. The descriptions of the various diseases are especially good, constituting vivid pen pictures of the lesions. The illustrations are largely original and for the most part as good as half tones can be made.

Two of the most important chapters are also the best—those treating of eczema and syphilis. The latter is especially well illustrated. Our space forbids a more detailed review, but it may be justly said that the book is a credit to author and publisher alike and a distinct contribution to medical literature.

A Manual of Clinical Diagnosis by Microscopical and Chemical Methods. For students, hospital physicians and practitioners. By Charles E. Simon, M. D., Professor of Clinical Pathology in the Baltimore Medical College. Sixth edition, revised. Octavo, 682 pages, with 177 engravings and 24 colored plates. Cloth, \$4.00 net. Lea Brothers & Co., New York and Philadelphia, 1907.

The author refers to his book as the "pioneer work in America" on this topic, and the preface to this, the sixth edition, mentions the changes necessitated since the first issue. The increased

interest in Clinical Diagnosis is well exemplified by the presence on the market of no less than four separate American volumes covering the whole subject, to say nothing of the numerous others limited to special fields, such as urinalysis and hematology. Simon's book contains the usual headings, including Blood, Secretions of the Mouth, Gastric Juice, Feces, Nasal Secretions, Sputum, Urine, Exudates, Cerebrospinal Fluid, Cystic Fluids, Semen, Vaginal Discharges, Milk, and Opsonins. There is an appendix describing the preparation of culture media and another giving an outline of a course in clinical microscopy.

It is remarkable how several books may cover the same ground and yet give such different impressions; Simon seems to be at great pains to describe minutely all procedures and conscientiously to set forth the chemistry, so far as possible. The views of different men on debated subjects are given, with usually the author's opinion to help. On the other hand the interpretation of laboratory examinations is not so thoroughly expounded and there is seldom a complete presentation of the laboratory findings in a given disease. For instance one must take great trouble to find out what the blood shows in leukemia and how the various leukemias differ from one another.

If a reader wishes to learn how to conduct a given test, what the chemistry of that test is, and what is its value, Simon's book is an excellent one to consult. It is probably more completely up to date than any other, and has all the advantages accruing from competent authorship, convenient arrangement, and good book-making. The index, like so many others, is inadequate; for example, one cannot find in it the names of common diseases, nor the names of men who have illuminated the various subjects, nor is there an index of illustrations, many of which, by the way, are excellent, especially the colored plates. It is convenient to find bibliography at the foot of each page.

The general effect of the volume is good beyond question; there is completeness, accuracy, and proportion, with enough of the writer's personality to lend interest.

Surgical Diagnosis. By Daniel N. Eisendrath, M. D., Adjunct Professor of Surgery in the Medical Department of the University of Illinois (College of Physicians and Surgeons). Octavo

of 775 pages, with 482 original illustrations, 15 in colors. Cloth, \$6.50 net. W. B. Saunders Company, Philadelphia and London, 1907.

Inasmuch as diagnosis is the most important branch of practical medicine, good books on the subject should always be welcome. This work by Eisendrath is a good book, because it approaches the subject of clinical diagnosis of surgical conditions in the proper manner. The author has made his groupings logically, presenting the problems in much the same manner as they come up for consideration at the bedside. Especial emphasis has been laid throughout on early differential diagnosis and some excellent tables setting forth the differential points in closely allied diseases are given.

There are few subjects in medicine in which illustrations can be used to better advantage than in surgical diagnosis, and this book is the best illustrated of any in its line. The illustrations are numerous, well chosen and particularly clear.

The text is comprehensive and well written.

The book can be especially recommended to those who have limited means for observation. The time consumed in not only reading it, but also in studying it, will be well spent.

The Practice of Pediatrics. By American and English authors. Edited by Walter Lester Carr, M. D., Visiting Physician to the Infants' and Children's Hospital, New York, etc. Octavo, 1014 pages; 199 engravings and 32 full-page colored plates. Cloth, \$6.00. Lea Brothers & Co., 1907.

During the past two years there have appeared an unusually large number of books on children's diseases, many of which have been reviewed in this department. In our judgment the present volume is one of the best of these recent works.

There are several features which make the book attractive and valuable. Among them may be mentioned an unusually large space devoted to the growth and development of the new born infant; chapters on infant feeding which, from the standpoint of the general physician, are especially clear and concise; editorial work which is unusually good, rendering the work of the authors systematic and molding the whole into a complete and comprehensive volume.

The list of authors contains a large number of well known names. They are Abt, Bovaird, Crandall, Davis, Jennings, McCarthy, Nicoll, Poynton, Riviere, Ruhräh, Southworth, Tuttle and

Yale. The illustrations are excellent.

The book completes the Practitioner's Library of Gynecology, Obstetrics and Pediatrics, the other two volumes being Bovee's Gynecology and Peterson's Obstetrics, both of which have been reviewed in this department. They are well printed on excellent paper and attractively bound in dark green cloth. The volumes are sold separately or in sets.

A Manual of Personal Hygiene: Proper Living upon a Physiologic Basis. By eminent specialists. Edited by Walter L. Pyle, M. D., Assistant Surgeon to the Wills Eye Hospital, Philadelphia. Third revised edition. 12 mo. of 451 pages, illustrated. Cloth, \$1.50 net. W. B. Saunders Company, Philadelphia and London.

There is no dearth of popular books on hygiene, but most of the so called "guides of health" are of questionable authorship or are written to exploit some particular fad. It is therefore a pleasure to recommend this book, written by well-known men and edited by Pyle. While it has been prepared especially for the laity, every physician will find in it many useful hints. The information is well systematized and an excellent index adds to the value.

It may be recommended to one's patients as the best book of its kind.

Diseases of the Rectum: Their Consequences and Non-Surgical Treatment. By W. C. Brinkerhoff, M. D., Chicago. 207 pages. Cloth, \$2.00. Urban Publishing Co., Chicago, 1907.

This cheaply printed book deals principally with the injection treatment of hemorrhoids. It is apparently written for the laity as an advertisement for the author's method. Results are dwelt upon at length; details of the method, as for example the composition of injected fluid, are withheld. The list of those using this method is remarkable for the large number of men, unrecognized by the profession, which it contains.

The book ends with a chapter on "The Legal Limitations of Medical Practice," which betrays the author's position.

The book is of very little, if any, value.

County Society News

CALHOUN.

The third quarterly meeting of the Calhoun County Medical Society was held in Marshall,

September 3. Twenty-three members were in attendance.

Dr. A. J. Read gave a profusely illustrated paper and demonstration on "Food Adulterants and Their Detection."

Dr. George C. Hafford, recently returned from Rochester, Minn., gave a very interesting talk on the Mayos and their work.

Seven new members were admitted to the society, bringing the total membership up to 79.

The annual meeting will be held in Battle Creek, December 3rd. Drs. Alvord, Zelinsky and Kimball were appointed a committee to make arrangements for the banquet.

A. S. KIMBALL, Sec'y.

HOUGHTON.

The regular monthly meeting of the Houghton County Society was held at the Douglass House, Houghton, September 2.

Dr. S. S. Lee, of Opechee, read a very instructive paper on "Diagnosis, Prognosis and Treatment of Hydrocele."

The annual election of officers then took place, which resulted as follows: President, Dr. W. P. Scott, Houghton; vice-president, Dr. W. T. S. Gregg, Calumet; secretary-treasurer, Dr. W. T. Whitten, Baltic; censor for three years to succeed Dr. E. T. Abrams, of Dollar Bay, Dr. A. I. Lawbaugh, of Calumet.

W. D. WHITTEN, Sec'y.

JACKSON.

The regular meeting of the Jackson County Medical Society was held at the Y. M. C. A. building on the afternoon of Sept. 5, 1907. The program consisted of papers and discussions concerning pulmonary tuberculosis. Dr. Frank Smithies, of the University of Michigan, discussed the Diagnosis of Beginning Pulmonary Tuberculosis; Dr. P. M. Hickey, of Detroit, presented Roentgenographs of tuberculous and other conditions of the chest; and Dr. W. E. Coates, of Onkama, gave a paper on the "Modern Treatment of Tuberculosis." The meeting was attended by a larger number of members than any before for many months, which fact coupled with the very able program made the afternoon a very profitable one for the society.

The society has purchased and distributed to each of the members, to other physicians of the county and to the clergymen of the Ministerial Association copies of the A. M. A. reprint of the "Great American Fraud." Each physician was also supplied with a copy of the Propaganda for Reform in Proprietary Medicines.

Last June the society held a public meeting to consider the milk supply of Jackson, as was reported in the Journal for July. The committee appointed at that time reports very gratifying results. Two of the larger dairies have taken up the work and are following the instructions of the committee in a very satisfactory way. Before the committee began work samples of milk collected showed uniform filthiness, while at the present time samples taken from the wagons of the "certified" dairies are remarkably clean, showing a surprisingly low bacterial content, at the same time maintaining a high physical quality. The certified dairies are obliged to charge but a very slight advance over former prices.

The post-graduate work of last season was so successful that steps are being taken to inaugurate the course for this year very soon on a somewhat larger scale, and extending over a longer period of time.

T. S. LANGFORD, Sec'y.

LENAWEE.

The Lenawee County Society held its August meeting at Devil's Lake, August 13th. The members and their wives arrived early in the day and welcomed guests from Hillsdale and Jackson Societies as both counties had been invited to meet with the Lenawee society.

A special dinner was served, after which the members gathered in a large hall for business, while the ladies were entertained with a boat ride on the beautiful lake.

Dr. Hafford, of Albion, gave a splendid paper on "The Patent Medicine Evil."

Dr. Eccles maintained his good reputation, with a paper on "Some of Our Mistakes and How to Remedy Them."

Dr. Colbath gave a very elaborate paper, "The Normal Stimuli of Peristalsis is Mechanical in the Treatment of Chronic Constipation."

The papers were well discussed, the members from Jackson and Hillsdale and Dr. Barrett, of Chicago, taking a lively interest in the discussions and giving us some good points.

After the regular program, a good social time followed.

The arrangements at the lake were in charge of Past President Dr. Town and every one present was well pleased with his effort to entertain us and will be happy to meet again at the same place.

J. C. JOHNSTON, Sec'y.

SHIAWASSEE.

The regular monthly meeting of the Shiawassee County Medical Society was held in the city of Owosso September 3. Eight members were present.

The name of Dr. Robt. C. Fair, of Durand, was suggested as a candidate for the vacancy on the board of county poor commission and the society pledged its support toward his election.

Dr. Flemming Carrow, of Detroit, gave a very instructive talk on "Ulceration of the Cornea."

Dr. T. N. Yeomans, of Bancroft, read a very interesting paper about his recent trip through the western states.

JAMES A. ROWLEY, Sec'y.

Correspondence.

AN APPEAL TO THE AMERICAN MEDICAL PROFESSION.

BY S. A. KNOFF, M. D.
New York.

On May 8, the day following the meeting of the National Association for the Study and Prevention of Tuberculosis, there appeared in the *North American* of Philadelphia a most sensational article by Mr. Richard J. Beamish, according to which, during the discussion of Dr. Flick's report on medication, I was reported to have advised the killing of dying consumptives quickly and painlessly by heavy doses of morphine, and to have admitted that it was my daily practice to do so. It was furthermore said in this article that there had been a bitter debate and that the session adjourned in confusion. These false statements were copied by nearly all the newspapers in the United States, were cabled to Europe and made the rounds in the papers and magazines of England and the whole European continent. In spite of explanations and denials I had sent to the Associated Press, in spite of a strong letter writ-

ten by Dr. George Dock, the presiding officer of the meeting and sent to the leading medical journals of America giving the true version of my remarks, the false statement has continued to be published and republished and commented upon to the great detriment of the anti-tuberculosis crusade all over the world. For example, ignorant consumptives in St. Louis who had read the sensational lie refused the visit of the nurses sent to them by the Society for the Relief and Prevention of Tuberculosis. The St. Louis *Republic*, which published this news item, said: "Consumptives since they read that report apparently have a dread that the visit of the nurse may mean morphine to end their suffering." It became thus necessary to issue the following statement by order of Prof. Frank Billings, president of the National Association for the Study and Prevention of Tuberculosis:

"Various daily newspapers published on May 8 what purported to be a report of the remarks of Dr. S. A. Knopf, of New York, before the National Association for the Study and Prevention of Tuberculosis, in which he was made to say: 'It is my practice and your sacred duty when you see a dying consumptive before you to give the sufferer morphine in plenty, that the end may come quickly and painlessly.'"

"No such statement was made by Dr. Knopf, but since, in spite of an immediate explicit denial by the doctor, a great many newspapers in this country and Europe continue to publish the false report as authentic news, Dr. Frank Billings, of Chicago, president of the National Association for the Study and Prevention of Tuberculosis, authorizes the following statement:

"Quite apart from the false position in which the speaker was placed and the injury done him, the publication of such a piece of sensationalism cannot fail to have a very deleterious effect upon impressionable tuberculosis patients throughout the country, and may keep others from seeking needed medical aid."

"The following statement made by Prof. George Dock, of the University of Michigan, who presided at the meeting in which Dr. Knopf spoke, should preclude all further misunderstanding:

"I heard clearly what Dr. Knopf said. I am sure that I know what he meant, and I am sure that everybody in the room must have understood what he said. His words could not possibly be converted into the meaning given in the public press. It was perfectly clear that he meant to

relieve patients in the last stages. Everybody knows this prolongs life, while making it very much easier for the patient."

"LIVINGSTON FARRAND,

"Executive Secretary."

I had hoped that this statement would put a stop to all further comments on and circulation of the sensational falsehood. I am free to confess that I have longed for the time when the lie would die out, for, in spite of the loyalty manifested by my professional friends during these hours of trial, for which I beg them to accept my most heartfelt thanks, the ordeal had become almost unbearable.

It seems that such a lie dies hard and from time to time receives a new stimulus from the overzealousness of some physician or layman. Thus, for example, through the courtesy of Dr. George H. Simmons, the editor of the *Journal of the American Medical Association*, I received a copy of the *Kansas City Journal* of last week, containing an editorial under the heading, "Should Doctors Kill?" from which I quote the following:

"The question whether a physician is justifiable in shortening the life of a patient suffering from an incurable disease by administering anesthetics was given a fresh impetus recently by the declaration of Dr. S. A. Knopf before the Tuberculosis Congress in Washington, advising that consumptives should be given hearty doses of morphine to hasten the end. To the credit of the profession it must be said that physicians generally repudiate the idea as atrocious and a violation of medical ethics. A Chicago physician, Dr. Charles Gilbert Davis, voiced this sentiment, saying: 'A physician who would make a statement of that sort should be taken out and hanged. The profession has not gotten so low that it must commit murder just because it has not discovered a cure for some disease. There is nothing incurable under the sun. Just because the cure has not been discovered that does not mean it never will.'"

In Dr. Dock's letter above referred to, as well as in the statement authorized by Dr. Frank Billings, the absolute falsehood of the respective newspaper reports was clearly shown, and it would seem that there was hardly an occasion for Dr. Davis to unburden his feelings for the benefit of the lay press.

Equally untrue was the report of the alleged "adjournment in confusion" and the "lively and bitter debate" which followed Dr. Flick's report

condemning the use of morphine and its compounds. In refutation of this reflection made by Mr. Beamish on a body of scientific men, composed of many of the leading American physicians who have devoted their lives to the study and prevention of tuberculosis, permit me to publish for the first time an extract from a letter which was received recently from Dr. Joseph Walsh, the secretary of the section:

"I was present as secretary of the section at which you spoke, and instead of the section breaking up in confusion, as was stated in the newspapers, the section closed in the perfectly regular way, and your statement as generally understood by the medical men seemed to be generally agreed with."

I beg the medical press of the United States to copy this communication in the hope that it will help individual members of the profession to refute once for all the inconceivable proposition that any physician true to his calling could possibly propound such a doctrine as shortening the life of any patient entrusted into his care. To the individual members of the profession in this country and abroad I address a personal appeal to embrace every opportunity to disabuse any individual who may labor under the misapprehension that I or anybody else of the American medical profession recommended shortening the lives of consumptives or any others by the administration of chloroform, morphine or similar narcotics. I make this appeal not merely for my own sake, but, above all, for the sake of truth and for the sake of consumptive sufferers in this and in other countries.

Edinburgh, September 4, 1907.

To the Editor:

Thinking that some of the surgical methods here might be of interest to the Michigan members of our profession, I append them.

Mr. Harold J. Stiles is doing excellent work at the Royal Edinburgh Hospital for sick children, at Chalmers Hospital and at his own private hospital. The work done at the first two institutions is entirely gratuitous and he gives to it from two and one half to three hours daily, four days each week. His method of operation is direct and simple, and the opposite of "fussy." He is not what might be called a rapid operator, but a very expert one and does a large number in a given time. The operating room is kept at a

temperature of about 72°. After the larger number of his operations, he uses no dressing whatever, merely dressing the wound with iodoform moistened in a bi-chloride solution. In the case of babies and children, they are prevented from handling the wound by a band with two armholes passed over the chest; then a tape is slipped through the armholes under the shoulders and fastened to the crib or cot at either side. Each ankle is wrapped with cotton and fastened to the side of the cot by a slip' noose of gauze. The child can move about considerably without disturbing the wound. The results of this form of dressing are uniformly good. The wound is perfectly dry and healthy from the beginning. Mr. Stiles or his assistants do not wear gloves. He asserts that he has never found it necessary or desirable and further that he can do cleaner work without the clumsiness that would affect it were he to wear gloves. His methods of sterilizing the field of operation and his hands are very simple, and alike in every respect, except that he uses a brush on his hands and nails, but never on his arms or on the patient's skin. The surface is thoroughly washed with a solution of liquid soap and spirits in equal parts, for perhaps ten or fifteen minutes, then with a one-half to one per cent lysol hot water solution and lastly with a one to sixty carbolic solution. He does not believe in a moist bi-chlorid pad over night because it makes the skin soft and sodden. The patients are taken directly from the operating room to the room, or ward, with open windows or doors where a temperature of 50° Fahr., and lower, prevails at this time. I have never seen an operator who possessed the facility that Mr. Stiles has of showing so clearly the operation step by step, so that when it is finished one has a thorough comprehension of his method.

Several other men here are doing excellent surgery, notably Mr. Annandale, who is Lister's successor, Mr. Thompson, Mr. Lewis, and Mr. Bremis.

I have found the surgeons here a most able, genial and approachable lot or gentlemen who seem to derive pleasure in showing and explaining their work and when I leave Edinburgh, it will be with a thorough appreciation of the opportunities given the seeker of surgical knowledge.

I have met many American physicians and surgeons over here from nearly every state who are getting a needed rest from their professional

work and learning the methods of our co-workers in the old world.

O. S. ARMSTRONG, M. D.

Vienna, August 23, 1907.

To the Editor:

The medical visitor of Vienna is, by right, well pleased with the large material of the General Hospital (Allgemeines Krankenhaus) and not less with the thoroughly scientific and practical manner in which patients are treated. Yet, in the general hospital, only people without proper means are received, and, necessarily, the hospital presents an appearance different from that generally seen in the United States. It may be mentioned that the venerable hospital in which, for many years, many a man from many a country has received instruction of incalculable value, is doomed, and already new, modern buildings are erected nearby and others are soon to follow. The old complex of buildings and the amiable and democratic Viennese relations, not only between teacher and student, but also between patient and physician, has become dear to everybody, so that we sincerely hope that the future may see a change in the outer appearance of this glorious cosmopolitan medical center, but that the old spirit may remain the same.

The physician who visits Vienna is, of course, interested to learn where the Vienna physicians treat their private patients. Only a few minutes' walk brings us from the general to one of the private hospitals of great reputation, in which the patients are treated by their own physicians and surgeons, although the superintending physician and several assistants may participate in the treatment to the extent demanded by the patient's own physician. In a wing of this hospital of one hundred and ninety beds, called the "Wiener Sanatorium—Anton Loen," Prof. von Noorden has his department for private hospital patients. As I had heard for years much about the place, I visited a part of it, namely the newly built annex for obstetrics and gynecology, which contains thirty beds. The quiet elegance of the building, the modern construction and, especially the introduction of some new appliances, besides the ingenious utilization of old principles, make this building appear to me as the, perhaps, most perfect institution, which I have had so far the privilege to see. No physician should neglect to pay a visit at least, to the working rooms of this

department. Of the details may be mentioned the following. The wash basins in the rooms adjoining the operating rooms are only used to receive the water which has passed the hands and forearms and they have a free outflow into a small gutter on the floor near the wall. Hereby a complicated structure is avoided and an obstruction is absolutely prevented. The faucets, of course, are not touched with the hands. One lever regulates the temperature of the spray which seems to be much more practical than the solid stream to which we have been accustomed. Sterilized metal boxes on each washstand contain the sterilized brushes which have gone through the centrifuge. The fact that a sterilized box has been used is made known by the absence of a ring that had to be removed to open the box. The boxes in which sterilized towels, etc., are kept are opened by the aid of a pedal and close by themselves. The lights in the operating rooms, I was told, produce an excellent diffuse illumination at night time. Under the whole glass case which contains the lights, a considerably larger glass plate is attached so that the heat is lessened and asepsis secured. The walls of the operating room are covered with white marble. The appliances for sterilization are equipped with a steam removing fixture so that no steam may enter the operating rooms proper. The principle is generally applied that the hands are not used to open boxes, etc. The sterilizing cases with their numerous subdivisions are rather large. Besides the instruments, the bottles with the saline solution, etc., a large kettle containing bowls and basins can be sterilized. In the obstetrical room two things engaged my attention more than others. One of them is the bath tub, which can be sterilized and which represents the fruit of considerable efforts. The patient is moved directly on a frame on top of the bath tub and the whole frame is gradually lowered so that no discomfort is encountered with the bath. It is called the aseptic submergeable bath tub.

The other feature is a bed, an invention of Dr. Lindenthal. This bed permits procedures on the patient without moving the patient and without disturbing her in her old position. On the first look the bed does not seem to be different from any other bed. In a few moments, however, the lower end of the bed, somewhere between the middle of the bed and the foot end, somewhat nearer to the center, can be unhitched and the distal end can be put aside, footrests can be

moved quickly into the proper position and the forceps can be applied on the patient, who now lies on an operating appliance. In the room for the infant, I noticed an ingenious apparatus which serves to regulate the moisture of the room.

The carpets, wallpaper and furniture in the social rooms can be washed and yet, in their appearance they would do honor to the most refined clubhouse. The mahogany furniture is prepared with a china-finish (Porcellanglasseur). The prices charged for room, meals and attendance seem to be reasonable in spite of the excellency of the equipment. Of course, the fee of the attending physician is a matter by itself. According to the circular, the daily expense for the patient amounts to 20-40 Kronen (about \$4.00 to \$8.00), according to the size and location of the room and the demands of the patient. There are no additional charges except for light and heat and for chemical, microscopical and bacteriological examinations which are charged at cost. Patients may bring their own midwives along if they wish. Accompanying parties are charged reasonably. Septic cases are not admitted. A garden lies between the buildings which constitute the sanatorium of which this annex is a part. The building and its equipment represent the results of the studies and experiences of many years, gained in the other parts of the institution.

EMIL AMBERG.

News

The following Detroit physicians have returned from summer journeys to Europe: C. W. Hitchcock, Angus McLean, George McKean, H. A. Haggerty, E. W. Haas, A. H. Steinbrecher, H. R. Varney, T. A. McGraw, M. A. Feckheimer, A. G. Studer, G. E. Potter, H. I. Wallace, H. W. Longyear.

Dr. Duncan Patterson, of Copac, was recently elected a delegate to the State Constitutional Convention.

Dr. J. M. Peebles, of Battle Creek, has arrived home after a prolonged tour around the world.

Dr. V. C. Vaughan, of Ann Arbor, is a delegate to the International Congress on Tuberculosis, held in Vienna, Sept. 16.

Dr. A. G. Grumwell, for two years surgeon on the U. S. S. Wolverine, has been assigned to duty on the battleship Kentucky.

Dr. Leininger, of Gladwin, has returned from a three months' trip abroad.

Dr. A. P. Burroughs, of Galesburg, has given up practice there and will remove to Grand Rapids.

Dr. R. C. Allen, of St. Joseph, recently sustained an ugly head wound in falling from his bicycle.

Dr. J. W. Bosman, of Kalamazoo, has returned from a two months' trip in Europe.

The Sorsen Private Hospital in Calumet will in the future be under the supervision of Dr. A. I. Lawbaugh, of the Tamarack Hospital staff.

A hospital, consisting of three wards, operating room, and other usual conveniences, is being provided for the Michigamme mine, to be under the charge of Dr. Leon L. Goodnow.

The State Sanatorium for Tuberculosis at Howell was opened August 19, and seven patients were admitted. An additional building will at once be commenced.

Dr. Robert Wells, of Ann Arbor, has been appointed assistant physician at the State Hospital, Traverse City.

Dr. A. B. Gregory, Ann Arbor, has been appointed assistant to the chair of otolaryngology at the University of Michigan.

Dr. George Dock, of Ann Arbor, has returned from a vacation spent in Colorado.

Dr. H. Beach Morse has entered practice in Bay City.

Marriages

Dr. Roger S. Morris, formerly first assistant in the medical clinic, at Ann Arbor, was married September 10, to Mrs. Mary Breasoe Carter. Dr. and Mrs. Morris will reside in Baltimore.

Dr. Hugh Dondna and Miss Ethel Cavanaugh, both of Lake City, were married August 21.

Dr. Henry Harrison and Miss Francis L. Tripp were married in Detroit, August 6.

Dr. Roy Bishop Canfield, of Ann Arbor, was married, August 6, to Miss Leila M. Harlow, of Boulder, Colo.

Dr. Walter S. Bell, of Elsie, to Miss Emily C. Hubbard, of Bellaire, at Traverse City, September 11.

Dr. Philip E. Moody, of Detroit, to Miss Fannie Stowell, of Lakewood, at the bride's home.

Dr. Robert Harper, of Detroit, to Miss Nellie Briggs, of Oxford, September 4, at Oxford.

Dr. John H. Charters, of Boyne City, to Miss Nellie D. Hansen, of Flint, September 11.

Dr. Charles J. Sorsen, of Calumet, to Miss Jerski Lang, of Finland, at London, England, August 26.

Deaths

Dr. Nathaniel Wilbur Webber died in Detroit, August 30.

Dr. Webber was born in Gardner, Me., but removed to Chicago at four years of age, receiving in that city his preliminary and medical education. The latter was interrupted by active service during the civil war. Leaving the Northwestern University after two years of medicine, he took the position of hospital steward in the Third Colorado Infantry and was rapidly promoted to the positions of assistant surgeon and surgeon, the latter appointment coming after a successful examination. He served throughout Sherman's campaign and was once a prisoner of war.

After being mustered out of the army in 1865, he returned to Northwestern University and received his medical degree in 1866. In 1869, he came to Detroit and assumed the chair of anatomy in the Detroit Medical College. He later took the chair of gynecology in the Detroit College of Medicine, and at the time of his death was Professor Emeritus.

A. W. Nicholson, M. D., of Newberry, died at his home on September 14, aged 63.

Cornelius W. Burrows, M. D., of Detroit, died of heart disease at his home on August 13, aged 68.

Francis J. Ducat, M. D., of Detroit, died suddenly in New York City, August 9, aged 39.

Charles J. Sorsen, M. D., of Calumet, died in London, England, of heart disease, Sept. 1, aged 37, only six days after his marriage.

Dr. Edwin Brumfield, of Jackson, a veteran of the Civil War, died at his home Aug. 4, aged 71.

Dr. John Bender, one of the pioneer physicians of Michigan, died September 11, at Lansing, aged 90 years.

He was born at Lancaster, Pa., April 4, 1817. He studied medicine and began the practice of his profession in eastern Ohio. In 1849 he was married to Mrs. Marie Whittaker of Pittsburg, Pa., and removed to Michigan the same year. He located at Adrian where he resided until 1867 when he moved to Lansing, where he had lived since.

The deceased leaves a wife, a son, Frank Bender, and three daughters, Mrs. Harriett Elliott, Mrs. Estella Willis and Mrs. Fred S. Lawrence.

Medical Co-Operation With Laboratory Work.—In his chairman's address before the Section on Physiology at the late meeting of the American Medical Association, W. R. BIERRING, Iowa City, Iowa (*Journal A. M. A.*, July 10) remarks the need of a closer medical co-operation with general laboratory investigation, and notices the measures taken to this end in the newer buildings of the Pasteur Institute at Paris, in the new city hospital at Munich, and in the plans of the contemplated institute at Vienna. In the former, a well-equipped pavilion for infectious diseases has been added to the old institute and the new biochemical laboratory. The combined laboratory of experimental medicine, physiology, etc., of the Johns Hopkins University, as well as other institutions in this country and abroad are also mentioned, and the broader conception of pathologic research of the newer medicine is emphasized. There is, he says, still need to insist on the importance of continued medical co-operation as an essential in all investigative work if we would keep scientific medicine in this country on a par with that of the old world.

Pneumothorax is very frequently of tuberculous origin, and is only rarely due to trauma.

For removing a portion of an enlarged uvula nothing compares with the forceps and scissors in efficiency. The tip of the uvula should be drawn slightly forward without strong traction, and the incision made upward and backward. The excision should be limited as much as possible to the mucous membrane, in order to avoid the marked irritation and pain which result when a raw stump of muscular tissue is left.

Progress of Medical Science

MEDICINE

Conducted by

T. B. COOLEY, M. D.

Passive Hyperemia in Acute Articular Rheumatism.—STEINITZ, after a discussion of the drawbacks of the current salicylate therapy in acute articular rheumatism, gives in detail the results obtained from the application of passive hyperemia according to Bier's method in the Moabit Hospital last year, comparing them with those obtained formerly from the salicylate preparations.

There were in all, during the period in question, 100 cases treated in this service, not all of which were suitable for the application of this method. The bandages could not, of course, be used in affections of the hip or spine, and only occasionally in affections of the shoulder. Severe simultaneous involvement of a number of joints was also considered unsuitable for the treatment. Varicose veins were another contraindication. Certain nervous patients proved unable to bear the application of the bandage. The continuance of severe pain after two applications was considered an indication for the administration of aspirin. In all, 81 cases seemed at the outset suitable for the treatment by hyperemia, and in 49 of them no other treatment was used.

A decided lessening of the pain occurred almost without exception—usually during and after the first application of the bandage, but sometimes not until after the second. It was observed that many of the patients slept better when the bandage was applied in the evening, and in several cases it was left on over night, though the usual method was to apply it twice a day for 2 or 3 hour periods. Another important effect noted was increased freedom of motion of the affected joints. A very slight increase in the swelling was usually noticed during the application of the bandage, which was not, however, edematous, and disappeared soon after the removal. Any lasting increase in swelling was not observed in any case. The fever subsided as a rule somewhat more gradually and slowly than when salicylates were used, but without any of the unpleasant accompaniments (severe sweating, etc.)

Comparing the results of this year, in which half the cases were treated by passive hyperemia, with those of the exclusive salicylate treatment of

the year before, it appears that there was little difference in the length of stay in the hospital; what difference there was being in favor of the newer method, however. Only 3% were discharged not cured, as against 5.3%.

With regard to complications aside from heart lesions no particular difference was observed. The cardiac lesions occurred, however, in only 8% of those treated with hyperemia, as against 26% of those receiving salicylates—a difference which STEINITZ considers important, although the salicylate cases were on the whole more severe. Furthermore, he thinks that these complications ran a more favorable course with the hyperemia than under salicylates.

He concludes that passive hyperemia may well be tried in the beginning of most cases of rheumatism. When the patients do not bear the bandage well, when the pain is not diminished by two or three applications, and when hip, shoulder, or spine, is severely involved, salicylates must be used—salicylates are indicated further in cases with considerable fever which does not subside in 4 or 5 days; in cases where the pain is diminished at first, but continues enough after 4 or 5 days to influence the general condition; and in cases where one joint after another is involved.

With recent endocarditis hyperemia is preferred.—*Zeitschr. für klin. Med.*, Vol. 64, p. 125.

Treatment of Gastric Ulcer by Senatro's Method.—SCHUETGEN reports the results obtained in 50 cases of gastric ulcer, treated according to Senatro's suggestions by feeding gelatin, fat and sugar. Twenty-eight patients were cured after an average of 20.5 days' treatment; 19 were at their request discharged improved after an average of 22.5 days. One was operated upon, and two died. In 94% of the cases, therefore, a favorable result was obtained in the relatively short time of 21.3 days. So far as can be judged from 50 cases it would seem that the results of Senatro's method are no worse than those of the ordinary therapy, while the brief duration of the treatment is an advantage.—*Ther. d. Gegenwart*, June, 1907.

SURGERY

Conducted by

MAX BALLIN, M. D.

Lead-Poisoning from Lead Bullets.—Lead bullets usually stay in the human body for years without causing any symptoms. BRAETZ found in literature only six cases of lead-poisoning starting from bullets left in the body after shot-wounds. It might be that these cases of lead-poisoning are much more frequent. The symptoms may not start until 17 years after the shooting and may start from very small projectiles, in one case, for instance, from three smallest shot weighing together 23 grs. The symptoms are the classical ones of lead-poisoning, but often only some of them (anemia, etc.,) may be present; also colic, lead line on gums and paralysis of the extensors have been caused by lead bullets. The logical treatment is removal of the lead shot from the body, after which the symptoms promptly disappear. In order to make an early diagnosis of beginning lead-poisoning in patients who have bullets in their bodies, examination of the blood is important. Grawitz has shown that in beginning saturnism, the basophile granules in the blood are constantly present, even before classical symptoms of lead-poisoning occur. These granules can be easily discovered (fixating with alcohol and staining with Loeffler's strong alkaline Methylene blue.)—*Congress of German Surgeons*, April, 1907.

Acute Abscess of Lung.—The operative result in 20 cases of acute abscess of the lung shows a mortality of 50 per cent. This seems high, but when we consider that cases are included of four and five months' duration before operation, and those of a dangerous character, we realize that we are dealing with severe lesions. Without operation all such cases must necessarily be fatal. Our hope of good results seems to lie in the simple abscesses which are discovered early, before they have become extensive, multiple, or complicated by empyema, and before the patient has grown septic. Cases of lobar pneumonia which run an irregular course suggesting secondary empyema, and in which pus is not obtained by trial puncture of the pleural cavity, should be regarded with suspicion. They should not be permitted to drag along in the medical wards until the favorable time for operating has passed. It is far safer to explore such cases by resection of one or more ribs, palpation and inspection of the pleura, search for an adherent area, and trial

punctures of the lung through the adherent portion. If pus is present in the lung, it should be found in this way at the time, or may be evacuated later spontaneously through the wound. If pus is not present, no harm has been done by the simple operative procedure at a time when the patient's general condition is good.—LILTON, *Annals of Surgery*, September, 1907.

"Gauze-Ether," or a Modified Drop Method with Its Effect on Acetonuria.—This method of etherization is as follows: A square pad of gauze twelve layers thick, and sufficiently large to cover the patient's mouth and nose extending well down over his cheeks, is laid directly on the patient's face. Ether is then dropped on this gauze by means of a drop bottle, consisting simply of an ordinary bottle with a small wick inserted through a slit in the cork. Ether having been dropped for about one minute on this pad of gauze described above, another similar pad is laid on the first, and the rapidity of the drops is increased and continued until the patient becomes thoroughly anesthetized. It is very important that the ether should be gradually administered in this way, and not poured on in large quantities at a time, which not only hampers the etherizer in getting the patient narcotized, but also is inconvenient on account of the possibility of getting ether burns on the face, respiratory spasm, or at least coughing. When, however, the ether is administered as directed, the strength of the vapor is so gradually increased that the respiratory tract becomes accustomed to it without any sense of suffocation on the part of the patient. The stage of excitement is as a rule not recognizable.

In a series of 102 cases the average time taken to produce complete surgical anesthesia was four minutes and twenty-nine seconds. The shortest time was one minute and a half, and the longest ten minutes. In the same series, the average amount of ether required to produce and maintain anesthesia was seven ounces per hour.

The advantages for the gauze method of etherization are; it is less disagreeable to the patient. Post-operative vomiting is reduced from nearly 100 to 33½ per cent. Quicker recovery to consciousness and reduction of post-operative acetonuria from 88½ to 26 per cent.—LADD AND OS-
GOOD, *Annals of Surgery*, September, 1907.

GYNECOLOGY AND OBSTETRICS.

Conducted by

B. R. SCHENCK, M. D.

Jaundice in the New-born.—GILLESPIE says that jaundice of the new-born is so common that it can hardly be called a disease, but occasionally the child is ill and requires treatment. You will look in vain for much assistance in works on diseases of children, and works on obstetrics are silent so far as practical suggestions are concerned. The obstetrician seems to assume that new-born babes require no treatment, the writer on pediatrics is usually one who does no obstetrics, and his experience is almost wholly with older children. He arrives at his opinions of the new-born by reasoning backward from children three or four months old. The result is a particularly dangerous form of error, that error which comes cloaked in the mantle of authority. There is another error of serious moment, the assumption that the child does not require drugs in its treatment.

If a large, full-blooded child is allowed to take all the blood in the after-birth before the cord is clamped or tied, you will have jaundice within two or three days, because more blood is present than it can use and a state of plethora is accompanied by a rapid destruction of blood cells. A feeble child should be allowed to take all the blood it can, in order to bridge it over until the milk supply is established, but the vigorous child is better off without it. This statement is based upon fifteen years of careful observation, and can be verified by any one who will take the trouble. If there is considerable extravasated blood, as in hemato-cephalocoele, its absorption may give an icteric hue. In these conditions no treatment is required.

If the urine is not loaded with bile salts, the stools do not show absence of bile, and no infection has occurred at the navel, the jaundice may be ignored.

If bile salts are present in the urine and absent in the stools, calomel and phosphate of soda are just as positively indicated as in older children and adults, and even more effective, unless some congenital defect in the biliary apparatus is present. A teaspoonful of a saturated solution of sodium phosphate may be given the new-born

child, every two or three hours before nursing, with very good effect, and may be continued as long as required.

If intestinal fermentation is present, salol, guaiacol, bismuth and other drugs of their class should be used as unhesitatingly as in older children.—*Cincinnati Lancet-Clinic*.

The Determination of Sex—Is It Subject to the Law of the Survival of the Fittest?—JACKSON says that we have ample ground for abandoning the theory that the male is a factor in sex determination. It seems evident that the ovum contains both male and female elements, and a separation of the two elements in the ovum before it is fertilized occurs. But since fertilization occurs after the maturation of the ovum we must look elsewhere than to the spermatozoon for the factor which causes the elements to divide. Since the female has no voluntary power over sex it is probable that the female element has no power to cause this division. Hence the mother as a factor must be excluded. The struggle for the fittest in the ovum may be the determining cause, the weakest polar bodies going under, and the stronger going on to development.—*Medical Record*, September 7, 1907.

Prolapse of Umbilical Cord.—Four cases of this obstetric accident are reported by SURE. All the cases occurred in multiparæ and all previous labors had been normal. An excellent review of the literature is given and the following treatment advised: In absence of signs of compression, transverse presentation or incomplete dilatation, wait for sufficient dilatation, and when considered sufficient, turn and extract immediately. If compression occurs during this period, turn, replace the cord, bring down one foot and do not extract until dilatation is complete. The reposition should be done after the version. When the breech is brought over the inlet, replace the cord and engage the breech thus blocking its way. Reposition as the operation of election is useless, for the prolapse will recur.—*Wisconsin Med. Jour.*, July, 1907.

PHARMACOLOGY AND THERAPEUTICS

Conducted by

H. A. FREUND, M. D.

The Influence of Antitoxin on Post-Diphtheritic Paralysis.—ROSENAU AND ANDERSON in a Bulletin from the Hygienic Laboratory publish a series of interesting and valuable experiments on "The Influence of Antitoxin upon Post-Diphtheritic Paralysis."

After a careful review of the statistics from the Metropolitan Asylum Boards, they conclude that the percentage of post-diphtheritic paralysis was greater immediately after the introduction of antitoxin and decreased gradually in later years due to larger dosage and earlier administration. Other reasons for the higher percentage of palsies when the use of antitoxin became general were that more patients recovered and suffered paralysis: and that the new form of treatment stimulated more careful and accurate observation.

Rolleston is cited as expressing the opinion that antitoxin does not make paralysis more likely, and that early administration, especially in the severe cases, makes palsies less likely to occur.

All the experimental work was done upon guinea pigs. The summary and conclusions of this valuable contribution are well worth quoting:

"Post-diphtheritic paralysis in the guinea pig is an almost exact counterpart of the same sequel in man.

In the guinea pig antitoxin cannot influence the diphtheritic paralysis after the paralysis has appeared.

Antitoxin has no influence in preventing post-diphtheritic paralysis if injected shortly before the paralysis develops.

Antitoxin given 24 hours after the infection can save the life of the guinea pig and greatly modify the paralysis.

Antitoxin, given in a single large dose 48 hours after the infection, did not modify the paralysis or save life. Thus, in our experiments 4,000 units failed to modify the paralysis or save the life of guinea pigs weighing about half a pound. *Weight for weight this corresponds to 400,000 units for a 50-pound child.*

Antitoxin given in repeated injections beginning 24 or 48 hours following infection seems to have a more favorable effect upon the subsequent paralysis than a single injection.

A very small quantity (1 unit) of antitoxin given 24 hours before or at the time of infection in our experiments prevented the development of paralysis.

In man we would expect more favorable results from the use of antitoxin than our work upon the guinea pig indicates, for we were dealing with an early and malignant form of experimental post-diphtheretic paralysis. This grave variety is, fortunately, rare in man. Further, we injected the entire charge of the poison directly

into the tissues of the guinea pig, while in man the toxin is doubtless elaborated more slowly. We may therefore assume that antitoxic serum, given at a somewhat later period than in our work upon guinea pigs, would exert beneficial effects.

The fact that one unit of antitoxin prevents paralysis and saves life when administered timely, whereas 4,000 units totally fails when delayed 48 hours, emphasizes the importance of using this sovereign remedy early."—*Hygienic Laboratory*.—Bulletin No. 38, June, 1907.

Acetonuria.—The presence of acetone in the urine does not result from the breaking down of fats and proteids in severe diabetes only. Acetonuria occurs in recurrent vomiting of children, in the pernicious vomiting of pregnancy, and in delayed chloroform poisoning as well.

Inasmuch as the source of the acetone bodies is mainly fats, the indications for treatment are the prevention of their formation and the breaking of the "vicious circle in autolysis." This can be brought about by diminishing the fat in the food, by administering carbohydrates and by neutralizing the acids already formed.

In the treatment of acetonemia in diabetes, carbohydrates must not be given in large amounts for the sugar cannot be utilized. Sodium bicarbonate should be freely administered until the urine is distinctly alkaline. Potassium citrate may be given in moderate doses in connection with the bicarbonate, or in mild acetonuria, 45 grain doses alone are particularly suitable. Rectal injections of sodium bicarbonate are unsatisfactory. Intravenous infusions frequently bring about a return to consciousness and prolong life for a short period.

In the recurrent vomiting of children in which the podromal symptoms of drowsiness, white stools, offensive breath, "muddy" complexion,—in short what are usually termed "bilious attacks," abnormal acids are generally present in the urine. The treatment should consist of small doses of grey powder or calomel, followed by doses of sodium bicarbonate up to 3 drams per day. Normal salt solution per rectum is useful. The food is best limited to a small quantity of carbohydrates.

Acetonuria often occurs in delayed chloroform poisoning. (1) Bilious attacks in children should be investigated: (2) Obese patients should be kept for a short time on a fat-free diet before operation: (3) Starvation and fright in children frequently give rise to an acidosis. For this, nutrient enemata before operation, are advisable.—W. L. BROWN. *Practitioner*, London, July, 1907.

PEDIATRICS

Conducted by

R. S. ROWLAND, M. D.

Pseudo-masturbation in Infants. RACHFORD defines pseudo-masturbation as a syndrome occurring in infancy and early childhood, which has been described in medical literature under the title "Thigh Friction," and "Infantile Masturbation." It is commonly accomplished with the child lying on its back; the thighs are flexed, crossed and pressed tightly together, closely embracing the external genitalia. In this position the infant makes a wriggling, or up and down body movement and rubs its thighs together. In other instances the genitalia are rubbed with the hands or feet or against some piece of furniture or other foreign object. These movements are apparently attended by a pleasurable excitement, the face is flushed and there is a marked increase in nervous tension. Following this act, which continues for a few minutes only, there is a general relaxation, accompanied by a mild perspiration, quiet contentment and in some instances sleep.

Pseudo-masturbation occurs as early as the fourth month, and the average age of onset in the cases reported is sixteen months; 48 of the cases collected occurred in females and 4 in male infants. In fully three-fourths there is a distinct neurotic inheritance. Illness influences the severity and frequency. Irritation of the nervous mechanism which controls the sexual organs is the all important exciting factor. The site of this irritation in the vast majority of cases is in the genito-urinary organs. Irritation and disease of the rectum and lower part of the large intestine may also be direct causes of this condition.

RACHFORD finds an acid condition of the urine (which irritates especially the female genitalia) occurs in more than one-third of the cases. This cause of irritation may be periodic, or rather, it may occur at intervals in infants of the gouty or bilious type. This occurrence of acid urine, with the local irritation which it produces, may explain many of the cases which have a tendency to periodic relapses. In this group the condition may be aggravated by a diet rich in meat-juice and meat-broths, which form so large a part a diet of some infants. Constipation is reported as being a factor in 6 of the cases in the table, and there can be no doubt but that it is one of the direct causes of pseudo-masturbation in infancy. Colitis, with the irritation which it produces in and about the rectum, and diarrhea of any kind, by reason of the irritating influence of the discharges on the genitalia, may be important factors in producing this condition. Diseases of the rectum, pin worms, tight and irritating clothing, uncleanness and eczema of the loia, are among other causes. In male infants, adherent prepuce, phimosis, balanitis and all conditions which may produce genito-urinary irritation may act as direct causes.

RACHFORD says the prognosis is very good. Of the 52 cases presented, 25 were cured, 7 were improved, 17 received no treatment and only two cases are reported in which the treatment was of "no avail."

From analysis of these cases, as well as from his own experience, he believes that the majority got well.

The disease is a habit neurosis, and time, with a normal development of the nervous system which tends to stability and greater inhibitory control, is the most important factor in the cure of the worst cases.

RACHFORD believes that there is almost no relation between pseudo-masturbation in infancy and true masturbation in later life. It is possible, however, that a badly neglected case of pseudo-masturbation occurring in a strong neurotic infant may continue until it becomes one of true masturbation in the child.

In treatment it is imperative that the habit be interrupted as soon as possible. As the act is performed, as a rule, while the infant is lying down, and commonly when it awakens from a sleep, and when the parts are more or less irritated by the soiled diaper, it is important that the nurse, by constant watching, shall be present forcibly to prevent the act by taking the child up, changing the diaper, cleansing the parts and dusting them with a soothing powder. The watchfulness of the nurse should continue throughout the waking hours of the child, so as to keep the parts always clean, dry and free from irritating discharges. The child should be kept in a sitting posture as much of the time as possible, and even when taken for an outing should, if old enough, be carried about in a go-cart in preference to the ordinary carriage. The nurse should be directed forcibly to interfere at all times to prevent the accomplishment of the act.

In children over two years, mild punishment is sometimes effective. Moral suasion should be practiced with older children.

In severe cases forcible restraint during sleep may be necessary. This may be practiced in many ways as by pinning the pajamas and by various mechanical devices.

Under general treatment he mentions the use of bromides and belladonna given at bed time.

Where the treatment is carefully looked after, one may count upon a permanent cure in the great majority of cases within one or two years. In those that are less carefully looked after, four or five years may be necessary to accomplish a cure.—*Archives of Pediatrics*, August, 1907, pg. 561.

DERMATOLOGY AND SYPHILIS.

Conducted by

A. P. BIDDLE, M. D.

The Present Status of Phototherapy.—FINSSEN and his disciples have conclusively proved the value of phototherapy in the cure of lupus vulgaris. The best results are obtained when all the details of treatment are carried out in accordance with the teachings of Finsen. In the light institute of Copenhagen better results are obtained than elsewhere by reason of the skill of the physicians and the experience of the nurses. Treatment with the high power (50 to 80 amperes) Finsen arc lamps is not at all adapted to office use, and is impractical even in hospitals, because of the size of the apparatus, the cost of the current, the duration of the individual treatments and the imperative services of a trained assistant.

The rationale of light treatment in lupus vulgaris is based on three main propositions: (1) The property of certain rays of the spectrum to destroy micro-organismal life. (2) Their ability to penetrate the skin. (3) Their power to produce reactive structural changes. Success in the light treatment of lupus depends, therefore, on the ability of the rays to penetrate, to kill bacteria and to inflame.

It has been demonstrated that the bactericidal effects of light is largely exerted by the blue, violet and ultra-violet rays. Some difference of opinion exists as to the manner in which the tubercle bacilli in the skin in lupus are destroyed. Finsen held that their death is due to the exclusive effect of the ultra-violet rays. This view is, however, not universally concurred in, many German workers contending that they are destroyed by changes induced in the tissues by the light. It is an established fact that light exerts an important influence on nutrient media. It has also been shown that the penetrating power of the various rays of the spectrum is in inverse proportion to their bacterial and chemical power. The red rays are the most penetrating and the ultra-violet the least. Most of the efforts in phototherapy in the past have been devoted to securing deep penetration of chemically active rays. Within the past few years the attempt has been made to increase the chemical activity of the penetrating rays.

The histologic changes effected in the skin by the action of light have been carefully studied by a number of observers. The findings are in general agreed on. There is a pronounced dilatation of the superficial and deep cutaneous blood-vessels with exudation of leucocytes. Light stimulates the epithelial cells and leads to nuclear division. After intense exposure degenerative changes in the epidermis may take place and the dead cells may be cast off through the formation

of blebs. The light also causes an increase in the number of connective tissue cells and a swelling of the collagen. At the height of the process the rete mucosum is thickened; and it has been demonstrated that light causes a hyperplasia of the epidermis and an abnormal cornification.

There are other diseases in which light may be employed to advantage, including lupus erythematosus, alopecia areata, acne, acne rosacea, flat vascular naevi, certain forms of eczema, leg ulcers, etc.

Light would doubtless have been more used as an auxiliary therapeutic measure in many cutaneous diseases had not the suddenly established reputation of the X-rays cast a shadow of obscurity over the milder acting agent. The ability of the X-rays to produce rapid and profound changes in cells and tissues constitutes at the same time the advantage and disadvantage of that treatment. Light energy, while much slower and much milder in its effect, is a perfectly safe remedy.

The much advertised high-power incandescent lamps have been viewed skeptically and not with much favor by dermatologists in general. Mercury vapor lamps have been in use for many years. The lamp made by Schott is called the "uviol" lamp, a convenient contraction of the term ultra-violet. Another is one of quartz with a water-cooling jacket made by Heräus of Hamburg.

In summing up his impressions as to the value of the mercury vapor lamp Schamberg says that it appears most capable of doing good in alopecia areata, leg ulcers and certain forms of eczema. The light is rich in chemical rays, but lacks deep penetration. These lamps have the advantage over others that a broad volume of light is emitted which can be conveniently applied over large areas. Another very pronounced advantage is that the grade of light erythema may be produced and even predetermined by the distance and duration of the exposure. The histologic changes produced by light have already been referred to; that a dilatation of blood vessels with exudation of fluid and corpuscles and regressive changes in pathologically altered cells occurs after the production of a distinct light erythema is evidence that in properly selected cases such treatment may prove beneficial.

Such phototherapeutic measures are to be viewed only as aids to other approved agents in the treatment of certain cutaneous diseases.—(J. F. Schamberg, M. D., Philadelphia, Section on Cutaneous Medicine and Surgery, A. M. A., Atlantic City, June, 1907.)